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Supreme Court, U.S.
FILED

No. 08-0845 JUL 7 2008

IN THE OFFICE OF THE CLERK
Supreme Court of the United States

BENEFIT RECOVERY, INC.,

Petitioner,

v.

JAMES J. DONELON,
in his Official Capacity as Commissioner of Insurance
for the State of Louisiana,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does § 1132 of ERISA preempt the Louisiana Commissioner of Insurance's Directive 175, which mandates inclusion of make-whole and attorney-fee-recovery subrogation provisions in ERISA plans delivered in Louisiana, because it is an attempt by the Commissioner to supplement the remedies available to ERISA plan beneficiaries?

2. Does § 1144(a) of ERISA preempt Directive 175 because it is a regulation having the effect of state law that relates to an ERISA plan?

3. Even if ERISA does not preempt Directive 175, can Directive 175 be valid as a federal rule of decision even if was improperly issued and incorrectly restates Louisiana subrogation law?

STATEMENT PURSUANT TO RULE 29.6

Petitioner Benefit Recovery, Inc. has no parent company, and that there is no publicly held company that owns 10% or more of its stock.

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Opinions Below

The March 11, 2008 opinion of the United States Fifth Circuit Court of Appeal is officially reported at 521 F.3d 326 (5th Cir. 2008), and is reproduced in the appendix. The Fifth Circuit's April 8, 2008 *per curiam* denial of rehearing and rehearing *en banc* is unreported and is reproduced in the appendix.

The December 6, 2006 opinion of the United States District Court for the Middle District of Louisiana and its April 11, 2007 denial of Benefit Recovery's motion to alter or amend are unreported, and are reproduced in the appendix.

Basis for Jurisdiction

The judgment of the United States Fifth Circuit Court of Appeal was entered on March 11, 2008, and the Fifth Circuit's unitary denial of rehearing and rehearing *en banc* was entered on April 8, 2008. This petition is timely under 28 U.S.C. § 2101 and Supreme Court Rules 13.1 and 13.3 because it is being filed within 90 days of entry of the order denying rehearing.

Statutory Provisions Involved

The two preemption provisions of ERISA are involved in this case. First, 29 U.S.C. § 1132 generally sets forth the scope of actions and remedies available to ERISA beneficiaries and fiduciaries, and preempts state laws purporting to provide additional actions or remedies.

Second, 29 U.S.C. § 1144(a) provides in relevant part that

> "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

Statement of the Case

Benefit Recovery's Business

For the past nine years, Benefit Recovery has been one of the nation's premier subrogation vendors, specializing in obtaining the greatest subrogation recovery possible for the health benefit plans with which it contracts. Some of these plans are located in Louisiana. Typically, a Louisiana health benefit plan pays for the treatment of accidental injuries sustained by a plan member, who by contract must notify the plan of any lawsuits begun against potentially responsible persons. The plan's terms usually permit it to subrogate to the member's rights and intervene in these lawsuits up to the amount the plan has paid for the member's treatment. Benefit Recovery, in turn, contracts with the health plans to exercise their subrogation rights, which are assigned in whole or in part to Benefit Recovery. Benefit Recovery's expertise enables it to obtain greater subrogation benefits than the heath plans would otherwise be able to get, and Benefit Recovery is paid a percentage of the subrogation recovery.

Each ERISA plan providing health benefits contains its own specialized provisions, but they often provide that the plan (and its agent, Benefit Recovery) can recover in subrogation the value of all of the benefits the plan has provided to the beneficiary, from the first dollar recovered by the beneficiary; Benefit Recovery's contract with Ochsner Health Plan, for example, provides that amounts recovered "shall be applied to reimburse" Ochsner for its expenses, regardless of whether this "results in the Member's partial recovery for his damages." Similarly, many plans do not contain provisions requiring the plans to reimburse the beneficiary for the attorney's fees incurred in pursuing this kind of tort claim.

The Louisiana Commissioner of Insurance Issues Directive 175

On January 8, 2003, the Louisiana Commissioner of Insurance issued Directive 175, which ordered health insurance issuers to begin incorporating into their plans (1) a provision making their recovery subordinate to the right of the insured to be made whole, and (2) a provision making them pay a share of the costs and fees incurred by the insured in obtaining any recovery against third parties:

> While insurers are free to include whatever provisions they choose in their policies, the provisions must be consistent with the laws and public policy of Louisiana. It has long been the public policy of this state, as expressed in Louisiana jurisprudence, that subrogation provisions in insurance contracts

> cannot harm the insured. This same rule of public policy applies to reimbursement provisions in insurance contracts. Further, an insurer in invoking a subrogation or reimbursement provision is required by the public policy of this state to contribute to the attorney's fees incurred in obtaining a recovery from the third party.
>
> . . . **The Commissioner will consider for approval language that clearly conveys to the insured that any right of recovery from third parties on the part of the insurer, whether by subrogation or reimbursement, is subordinate to the insured's right to be fully compensated for his damages; and that the insurer is obligated to share in the legal expenses incurred.** The Commissioner will not approve policy language that excludes and/or reduces coverage for expenses incurred as a result of the treatment of injury or sickness caused by the fault of a third-party (emphasis added).

A plan provision of the sort required by Directive 175 will radically change the way subrogation works for some plans. Benefit Recovery will no longer be able to obtain full reimbursement for amounts advanced by the plans. Rather, Benefit Recovery is subrogated to the amounts received only after the beneficiary has been fully compensated — and, if the amount paid in settlement is less than the general and nonmedical damages sustained by the beneficiary, under Directive 175 the beneficiary can keep the entire amount paid in settlement or

judgment. Further, even if the beneficiary were to obtain a settlement or judgment in excess of his or her loss, Benefit Recovery can only recover a portion of the benefits it provided if (1) the settlement or judgment is greater than the beneficiary's nonmedical damages, ***and*** (2) if that happens, Benefit Recovery must share in the attorney's fees incurred by the beneficiary in obtaining a recovery.

After the Commissioner promulgated Directive 175, it rejected proposed health insurance coverage forms from Ochsner Health Plan — a company that contracted with Benefit Recovery — as well as several other large health plans because the forms did not comply with Directive 175. By law, these health insurers are prohibited from using any form in Louisiana that is not approved by the Commissioner, and Directive 175 itself warned that insurers who certified compliance and later used a prohibited form "will be subject to sanctions including but not limited to the imposition of such fines as are authorized by law."

Procedural History in the Courts Below

Benefit Recovery filed suit in the United States District Court for the Middle District of Louisiana, seeking (1) a declaratory judgment that ERISA's conflict preemption and complete preemption provisions (29 U.S.C. §§ 1132 and 1144(a)) displaced Directive 175, at least insofar as it applied to ERISA health benefit plans; and (2) an injunction against further enforcement of this directive to ERISA plans. Benefit Recovery further alleged that Directive 175 was invalid because

it was improperly promulgated and did not correctly reflect state law. Federal jurisdiction existed over Benefit Recovery's claims under 28 U.S.C. § 1331.[1]

On April 16, 2004, the district court determined that it would not permit Benefit Recovery to question the substantive validity of Directive 175 as a matter of state law, granting the Commissioner's motion to dismiss Benefit Recovery's state claims under the Eleventh Amendment without addressing whether Directive 175 could be challenged as a suspect state law providing a federal rule of decision. Following discovery, the parties filed cross-motions for summary judgment, focusing solely on whether Directive 175 was preempted by ERISA's complete preemption provision, § 1144(a). On December 5, 2006, the district court denied Benefit Recovery's summary judgment motion and granted the Commissioner's motion. The district court applied the test announced by this Court in *Kentucky Assoc. of Health Plans, Inc. v. Miller*,[2] which held that state action falls within the ERISA preemption savings clause if (1) the action is a state law that is specifically directed toward entities engaged in insurance, and (2) the state law substantially affects the risk pooling arrangement between the insurer and the insured. First, the district court held that Directive 175 is a state law under ERISA, viewing the scope of the preemption clause and the scope of the savings clause as identical. Second, the district court found that Directive 175 affects the risk pooling arrangement between the insurer and the

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[1] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n. 14 (1983).

[2] 538 U.S. 329 (2003).

insured because it controlled the terms of the policies offered to beneficiaries. Finally, the district court rejected Benefit Recovery's effort to challenge the substantive underpinnings of Directive 175, basing this determination on its prior ruling that Benefit Recovery's claims under state law were barred by the Eleventh Amendment. One day later, the district court entered a final judgment dismissing Benefit Recovery's entire case, even though the parties had only submitted the issue of § 1144(a) preemption to the court in their summary judgment motions.

After the district court denied Benefit Recovery's Rule 59(e) motion to alter or amend, Benefit Recovery appealed the district court's decision to the United States Fifth Circuit Court of Appeal.[3] On March 11, 2008, the Fifth Circuit affirmed the decision of the lower court, rejecting two of Benefit Recovery's arguments on procedural grounds and one on a substantive basis. First, the Fifth Circuit held that Benefit Recovery did not preserve for appeal the issue of whether § 1132 preempted Directive 175, reasoning that Benefit Recovery did not present this issue to the lower court in its summary judgment motion and neglected to brief the assignment of error until its reply brief. Second, the court affirmed the decision of the lower court that § 1144(a) did not preempt Directive 175 under the *Miller* test. Finally, the Fifth Circuit held that Benefit Recovery raised the issue of whether Directive 175 was valid as a surrogate federal rule of decision too late, and waived this issue from consideration by the district court.

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[3] Because Benefit Recovery's appeal was timely from the district court's December 6, 2006 final judgment, the court of appeals had jurisdiction under 28 U.S.C. § 1291.

Reasons for Granting the Petition

This is an ERISA case. As lower courts have bemoaned time and time again, the provisions of ERISA are confusingly written, and the reasoning in the legal decisions interpreting the statute shift like the sands of time. But the statute is as important as it is cumbersome, and its provisions intimately affect the lives of millions of Americans.

The ERISA preemption provisions are among the most important in federal law. Without them, ERISA's promises of standardized benefits available under federal law are illusory. Yet if the lower court's decision is permitted to stand, each and every state in the union will be able to avoid ERISA preemption with ease by abdicating its legislative prerogative and simply permitting (or, indeed, mandating) its insurance commissioner to gin out regulation after regulation purporting to affect all insurance policies or ERISA plans in the state. ERISA must be safeguarded against this sort of state overreaching.

Argument

A. ERISA preempts Directive 175.

The Employee Retirement Income Security Act of 1974 is a landmark statute designed to establish predictable nationwide standards for employee benefit plans.[4] To achieve ERISA's purpose of providing a "uniform regulatory regime over employee benefit

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[4] *See generally* 29 U.S.C. § 1001(b).

plans," the statute contains two separate and independent preemption provisions. First, § 1132 provides an "integrated system of procedures for enforcement" of ERISA rights, and Congress' policy choices regarding "the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA."[5] Accordingly, § 1132 has "extraordinary" preemptive power, and completely preempts state attempts to alter or supplement the remedies it gives to plan beneficiaries.[6] Second, § 1144(a) of ERISA is a conflict preemption provision, mandating that ERISA preempts and supersedes all state laws that "relate to" employee benefit plans.

The application of ERISA's preemption provisions should be straightforward, and Benefit Recovery respectfully submits that this Court should accept certiorari to review the Fifth Circuit's erroneous decision that neither § 1132 nor § 1144(a) preempt Directive 175. Lower courts have continually lamented the fact that deciding ERISA preemption issues means a "descent into a Serbonian bog wherein judges are forced to don logical blinders and split the linguistic atom to decide even the most routine cases."[7] This case

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[5] *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

[6] *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987).

[7] *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 454 (3d Cir. 2003) (concurrence of Judge Becker).

presents a unique opportunity to provide a bridge over that bog.

1. § 1132 preempts Directive 175 because it is an impermissible attempt by the Commissioner to provide ERISA beneficiaries with supplemental remedies against their plans based on his personal interpretation of state law.

Although the district court did not address § 1132 preemption and the Fifth Circuit refused to consider it, the governing standards for § 1132 preemption established in *Aetna Health Inc. v. Davila*[8] govern this case and demonstrate that Directive 175 is completely preempted.

a. Benefit Recovery preserved for appeal the issue of § 1132 preemption.

The Fifth Circuit avoided reaching the merits of § 1132 preemption by finding that Benefit Recovery had waived this issue on appeal. The flaw in the Fifth Circuit's reasoning lies in conflating the legal error Benefit Recovery believed the district court committed (rejecting Benefit Recovery's argument that § 1132 preempted Directive 175) with the procedural mechanism used by the district court (dismissing Benefit Recovery's § 1132 claim after the parties filed cross-motions for summary judgment addressing only § 1144(a) preemption).

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[8] 542 U.S. 200 (2004).

It is undisputed that Benefit Recovery pleaded complete preemption under § 1132 of ERISA in its original Complaint and preserved this claim in the pretrial order, pressing it to the district court. It is similarly uncontested that neither Benefit Recovery nor the Commissioner submitted the § 1132 preemption claim to the district court on summary judgment. Nevertheless, the district court's final judgment dismissed Benefit Recovery's entire case, including both the claim presented to it on summary judgment as well as the unsubmitted claim that § 1132 preempted Directive 175. Accordingly, when Benefit Recovery appealed to the Fifth Circuit, the very first issue presented for review in its original brief was whether § 1132 preempted Directive 175, and Benefit Recovery argued this point for ten pages.

Benefit Recovery did not raise the procedural mechanism used by the district court (dismissing its § 1132 preemption claim *sub silentio*) as an independent error to the Fifth Circuit. Perhaps the district court did, in fact, commit an additional error — aside from the ***substantive*** error of rejecting preemption under § 1132 of ERISA, which Benefit Recovery preserved for appeal and completely briefed, from a ***procedural*** standpoint the district court acted wrongly in dismissing Benefit Recovery's § 1132 claim because that claim was not before it on summary judgment. But regardless of whether the district court committed this additional procedural error by going beyond the scope of the summary judgment pleadings, the effect was patent: the district court dismissed Benefit Recovery's § 1132 claim on the merits. This was the legal error Benefit Recovery believes the district court committed, this was the legal

error appealed to the Fifth Circuit, and this was the legal error briefed by Benefit Recovery.[9] Accordingly, the Fifth Circuit erred in failing to reach the merits of § 1132 preemption.

b. § 1132 preempts Directive 175.

The seminal case on § 1132 preemption remains this Court's 2004 decision in *Davila*, which involved two consolidated cases arising in Texas. In one, an ERISA plan beneficiary was denied the medication of his choice, and suffered personal injuries from the substitute medication required by his plan; in the other, an ERISA plan beneficiary was denied continued coverage for a lengthy hospital stay, and sustained personal injuries when she was forced to leave the hospital prematurely.

Both beneficiaries sued their plans for allegedly violating duties imposed by the Texas Health Care Liability Act. As a result, the central question in *Davila* was whether the plaintiffs could access state law remedies established under the Texas Health Care Liability Act or whether those supplemental remedies

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[9] Indeed, it would have been inappropriate for Benefit Recovery to raise the procedural error of the district court in its original brief. At the time Benefit Recovery appealed this case, Benefit Recovery did not know that the Commissioner intended to argue that Benefit Recovery's § 1132 claim should have been submitted to the district court at the summary judgment stage, relying on the notion that the cross-motions for summary judgment were the functional equivalent of a trial. Once this procedural argument was made for the first time in the Commissioner's brief, Benefit Recovery responded in its reply brief.

were preempted by ERISA. On appeal, the Fifth Circuit held that the Texas Health Care Liability Act was not preempted because it created an "an external, statutorily imposed duty" that fell outside the scope of ERISA.

This Court reversed. The Court began its analysis by stressing that the remedies established in § 1132 are exclusive:

> The limited remedies available under ERISA are an inherent part of the "careful balancing" between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.[10]

The Court reasoned that allowing states to provide additional remedies to ERISA plan beneficiaries would marginalize the remedial scheme established in § 1132:

> The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The six carefully integrated civil enforcement provisions found in [§ 1132] of the statute as finally enacted provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.

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[10] *Davila*, 542 U.S. at 215.

> Therefore, **any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.**[11]

As a result, the Court concluded that the Texas Health Care Liability Act was completely preempted by § 1132, and rejected the argument that § 1132 preemption is limited by the savings clause established in § 1144(b)(2)(A):

> ERISA [§ 1144(b)(2)(A)] must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA [§ 1132]. Under ordinary principles of conflict pre-emption, then, **even a state law that can arguably be characterized as "regulating insurance" will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.**[12]

The principles established in *Davila* govern this case and demonstrate that Directive 175 is preempted by § 1132 because it conflicts with ERISA's exclusive remedial scheme. The six "carefully integrated civil enforcement provisions" do not provide ERISA

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[11] *Id.* at 208-09 (emphasis added; citations omitted; italics in original).

[12] *Id.* at 217-218 (emphasis added).

beneficiaries with rights and remedies consistent with the make-whole doctrine or attorney-fee-recovery principles. This Court has made it abundantly clear that the decision whether or not to include these requirements as a matter of federal law falls within the singular power of Congress to legislate.[13] States are not free to engraft their own make-whole and attorney-fee-recovery provisions onto ERISA, nor can their insurance commissioners, through the back door, accomplish precisely the same result by ordering ERISA plans to include these provisions.

Although this Court need do no more than apply the principles established in *Davila* to determine that Directive 175 explicitly conflicts with § 1132, further support for forbidding the wholesale importation of the make-whole doctrine or an attorney-fee-recovery provision into the scope of remedies available to ERISA beneficiaries can be implied from the methodology of virtually all of the lower federal decisions that have examined ERISA subrogation. There is currently a split in the circuits about what to do if a plan is silent or ambiguous about the make-whole doctrine. Some circuits, as a matter of federal law, have held that if an ERISA plan is silent on the matter, the plan may only recover in subrogation after the insured is made whole;[14]

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[13] As the Court has stated on no less than three separate occasions, Congress "did *not* intend to authorize other remedies" in addition to § 1132 "that it simply forgot to incorporate expressly." *E.g., Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (italics in original).

[14] *E.g., Cagle v. Bruner*, 112 F.3d 1510, 1521 (8th Cir. 1997); *Barnes v. Independent Auto. Dealers Ass'n of California Health and Welfare Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995).

others disagree.[15] But even the circuits that have applied the make-whole doctrine to ERISA plans have done so by recognizing that the make-whole doctrine is a general tenet of subrogation law that can form federal common law as a gap filler if the ERISA plan was silent.[16] What these circuits have not done is apply state subrogation law to the ERISA plans at issue. The reason is simple: in *FMC Corp. v. Holliday*,[17] this Court held that a Pennsylvania antisubrogation statute (making subrogation unavailable in actions arising out of automobile accidents) was completely preempted insofar as it applied to ERISA plans. Accordingly, federal courts have uniformly recognized that the provisions of state subrogation law should never govern the determination of whether the make-whole doctrine or related subrogation tenets may be applied to an ERISA plan.[18]

The point here is that, even if Louisiana had adopted a formal statute requiring the make-whole doctrine and the payment of a portion of the beneficiary's attorney fees, this statute would certainly not be applied in the face of contrary language in an ERISA plan, and could not even be used as a gap filler if an ERISA plan was

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[15] *Sunbeam-Oster Co., Inc. Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees v. Whitehurst*, 102 F.3d 1368, 1378 (5th Cir. 1996).

[16] *E.g., Barnes*, 64 F.3d at 1395.

[17] 498 U.S. 52 (1990).

[18] *Paris v. Iron Workers Trust Fund*, 211 F.3d 1265 (4th Cir. 2000) (table; text in Westlaw); *Cagle*, 112 F.3d at 1521; *Barnes*, 64 F.3d at 1392-93.

silent or ambiguous. And if Louisiana cannot, through positive legislation, grant those remedies to ERISA plan beneficiaries, then surely the Louisiana Commissioner of Insurance cannot do so by trying to force ERISA plans to include language in the plan document itself.

In fact, unless this Court grants this Petition and reverses the court below, the structure, function, and exclusivity of the remedial scheme established in § 1132 will be severely undermined. If Directive 175 survives preemption, state legislatures across the country will be able to circumvent the scope of complete preemption with alarming ease. To avoid the specter of complete preemption, legislatures will abandon the practice of enacting statutes that provide external statutory remedies (which are clearly preempted under *Davila*), and instead simply force insurers to incorporate those remedies into the terms of their ERISA plans. This future legislation will, in essence, be insulated from § 1132 preemption by precluding the claims that typically trigger complete preemption from ever arising. After all, once the supplemental remedies are forcibly imbedded in the terms of an ERISA plan, § 1132 would arguably preserve them by enabling ERISA plan beneficiaries to enforce their rights under the plan. In that circumstance, the insurers could only challenge the legislation through the preemption clause established in § 1144(a) — which is limited, of course, by the savings clause. That result would be fundamentally inconsistent with this Court's ruling in *Davila* that "even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate

vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."[19]

Directive 175's pernicious effect can be viewed in another way. In *Sereboff v. Mid Atlantic Medical Serv., Inc.*,[20] this Court held that a plan seeking contractually to recover benefits it paid to a plan beneficiary who receives a tort recovery from a third party asserts an equitable claim under § 1132. In effect, then, apart from supplementing the remedies available to an ERISA beneficiary, Directive 175 impermissibly supplants the equitable remedies ERISA plans themselves would have to recover the full extent of their payments by limiting their contractual subrogation rights.

In *FMC* this Court aptly identified the danger to Congress' intent in passing ERISA if state subrogation provisions were permitted to apply to ERISA plans, and noted that "to require plan providers to design their programs in an environment of different state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."[21] The very same concern is present in this case. If the Fifth Circuit's failure to find Directive 175 preempted is allowed to stand, the integrity of ERISA's remedial scheme will be jeopardized and ERISA plans will be placed in the same morass they would have been had

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[19] *Davila*, 542 U.S. at 217-218.

[20] 547 U.S. 346 (2006).

[21] *FMC Corp.*, 498 U.S. at 408-09.

the Pennsylvania antisubrogation statute been upheld. This is precisely what Congress sought to avoid when enacting ERISA.

2. § 1144(a) preempts Directive 175, a "State law" that "relate[s] to an employee benefit plan."

§ 1144(a) mandates that ERISA shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." The Fifth Circuit correctly found that Directive 175 falls squarely within this provision, but erred in finding that it also fell within the clause saving insurance statutes from § 1144(a)'s preemptive effect.

a. Directive 175 is a state law that relates to an employee benefit plan for purposes of § 1144(a).

§ 1144(a) provides that all "State law[s]" that "relate" to an ERISA plan are preempted. Initially, the Fifth Circuit correctly held that Directive 175 is a "State law" under this provision. "State law" is defined in § 1144(c)(1), which provides that it "includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." Accordingly, because Directive 175 has the effect of law, there is no need to engage in a "metaphysical inquiry into the nature of 'law'" (in the words of the Fifth Circuit) in order to find that Directive 175 falls within the scope of § 1144(a). The Louisiana Insurance Code recognizes that if a company violates one of the Commissioner's directives, it is subject to monetary penalties just as if

it violated any other provision of state law,[22] and the "hand of the state firmly, though not harshly, requires compliance" with Commissioner directives, making them have the effect of law. The Fifth Circuit was also correct in holding that Directive 175 "relate[d] to an employee benefit plan." In *FMC* this Court held, in no uncertain terms, that a state antisubrogation provision related to an employee benefit plan.[23]

b. Directive 175 does not fall within § 1144's savings clause.

1) Directive 175 is not a "law of any State."

Although the Fifth Circuit concluded that Directive 175 fell within § 1144(a), it erred in holding that Directive 175 is saved from preemption under the savings clause, § 1144(b)(2)(A).

First, the Fifth Circuit failed to recognize that the scope of the savings clause is not nearly as broad as the scope of the preemption clause. Although the savings clause was designed to ensure that states could retain some authority over the regulation of insurance, banking and securities, Congress did not employ the same sweeping definition of "State law" to govern its application. Rather, the savings clause provides that:

> Except as provided in [the deemer clause] nothing in this subchapter shall be construed

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[22] LSA-R.S. 22:1316 A.

[23] *FMC Corp.*, 498 U.S. at 408-09.

> to exempt or relieve any person from **any law of any State** which regulates insurance, banking, or securities."[24]

There is a fundamental, albeit subtle, distinction between the phrase "any law of any State" used in the savings clause and the term "State law" used in the substantive provision. As noted above, "State law" is a term of art which is explicitly — and expansively— defined in § 1144(c)(1). When Congress defined the scope of the preemption clause, it went out of its way to ensure that ERISA would preempt not only "law," as the term is traditionally defined, but also "any State action having the effect of law." Given that ERISA is "a comprehensive and reticulated statute, the product of a decade of congressional study of the Nation's private employee benefit system,"[25] Congress' decision not to extend the savings clause to all "State law" cannot be viewed as a simple oversight.

But Congress explicitly limited the application of the savings clause to "law" regulating insurance, banking, or securities. Because the word "law" was used in the savings clause outside of the statutorily defined term "State law," the rules of statutory construction require this Court to interpret the word according to its plain

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[24] 29 U.S.C. § 1144(b)(2)(A) (emphasis added). The deemer clause is not implicated in this action because Directive 175 is not applicable to self-funded health plans.

[25] *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002).

meaning.[26] When the savings clause is read in that context, it becomes unmistakably clear that Directive 175 is not saved from preemption. As a result, Directive 175 is preempted by § 1144(a).

The Fifth Circuit came very close to accepting this argument, damning it with faint praise by finding that it was a "not-absurd proposition" that may have "intuitive merits." The reason the Fifth Circuit ultimately rejected it is less clear:

> **We conclude that any "State law" as defined in the preemption provision qualifies as the "law of any State" for the purposes of the savings clause.** The savings clause was phrased with "similar breadth" as the preemption clause. The Court observed this in the process of holding that a judicially created notice-prejudice rule regulated insurance and therefore was saved from preemption. **If a judicial rule can be a state law, it is far from certain where we would draw the dividing line between "State laws" and "laws of any State."** Given the similar breadth of the clauses, if statutes and state supreme court decisions are State laws, it follows that rules, regulations, and anything else having the effect of law are as well (emphasis added)

But every judicial decision must make distinctions and draw dividing lines between what is acceptable and what

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[26] *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340 (1997).

is not; this is the nature of our system of justice. And this case presents a signal opportunity for this court to draw the very line the Fifth Circuit refused to craft. Benefit Recovery suggests that a logical dividing line is this: the "laws of any State" that are saved are those statutes and regulations that are properly promulgated under the relevant state's laws. After all, the very purpose of the savings clause is to protect laws of general applicability passed by state legislatures that wish to regulate insurance. On the other hand, if a state insurance commissioner decides on his or her own volition to interpret the state's insurance law in an idiosyncratic or unsupported fashion, there is no reason that determination should be saved from preemption.

This reading of the savings clause is consistent with the legislative history of ERISA, which is a key consideration.[27] As noted above, ERISA's preemption clause was designed to insulate ERISA plans from a multiplicity of state legislative enactments. Accordingly, Congress chose deliberately expansive language, recognizing in § 1144's definitional section that state actions might affect ERISA plans even if the actions didn't fall within the traditional understanding of what was a law. By contrast, the savings provision recognized that state insurance laws of general applicability probably would not harm the intent of Congress in creating a uniform statute; a second undercurrent of the ERISA savings clause is a concern for federalism — Congress did not want to dictate to states the manner in which they legislated insurance. But this concern is absent when a regulation issued by a state insurance

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[27] *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 204 (1985).

commissioner without proper statutory foundation is at issue. These regulations are the product of one person who, albeit elected, does not speak for the state.[28]

As the Fifth Circuit recognized, the § 1144(b)(2)(A) savings provision is designed to be ***narrowly*** read.[29] It would not be consistent with the narrow scope of the savings clause to read its phrase "law of any State" in the same way the phrase "State law" is used in the ***expansive*** preemption clauses. The purpose of the preemption clause was to prevent anything having the effect of law from affecting an ERISA plan. The purpose of the savings clause was to carve out a limited exception for state insurance laws.

2) Even if it were a "law of any State," Directive 175 is not saved from ERISA preemption because it fails the *Miller* test.

In *Kentucky Ass'n of Health Plans, Inc. v. Miller*,[30] this Court held that in order for a state law to be one

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[28] Notably, here the Commissioner's stated substantive underpinnings for Directive 175 find their origins only in state laws of general application, not those relating to the insurance industry. Completion of the savings clause analysis requires delving into the underlying basis for the Commissioner's Directive and this obligation cannot be avoided by suggesting that this is an issue of state law as to which the Commissioner enjoys immunity from federal attack.

[29] *Pilot Life*, 481 U.S. at 46 (citations omitted).

[30] 538 U.S. 329 (2003).

which "regulates insurance" under the savings clause, it must (1) "be specifically directed toward entities engaged in insurance," and (2) "substantially affect the risk pooling arrangement between the insurer and the insured."[31] The Fifth Circuit found that both prongs of this test were met, determining that Directive 175 affected risk pooling because it affected the terms of the insurance policies to which it applied:

> Benefit argues that the "risk pooling" at issue is different from that identified in *Miller*, in which the Court determined that an "any willing provider" requirement, which prevented discrimination against any provider willing to meet the terms and conditions in the ERISA plan, was not preempted.
>
> In *Miller*, the Court read the second prong to apply whenever a law "alters the scope of permissible bargains between insurers and insureds." Directive 175 certainly alters the permissible bargains between insures and insureds by telling them what bargains are acceptable. Accordingly, the Directive affects "risk pooling" and is therefore saved from Section 514 (Section 1144) preemption.

But even assuming that Directive 175 is a state law directed to entities engaged in the insurance business (and there is no evidence that this is the case,

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[31] *Id.* at 342.

considering that it is directed only at ***health*** insurers, not insurers as a whole), there is no evidence in the record concerning the extent to which it affects risk pooling. Moreover, even if evidence was not required to support a determination about the effect of Directive 175 on risk pooling, the lower court's ruling was in error as a matter of law. In *Baxter v. Lynn*,[32] the Eighth Circuit analyzed the applicability of the savings clause to state subrogation laws and concluded that:

> The practice of subrogation does not transfer the risk from a policyholder to his or her insurer. Rather it limits the recovery available to the policyholder by preventing a double recovery.[33]

The critical point here is that subrogation does not transfer or substantially affect ***the risk insured against***.[34] In the context of a health benefit plan, the

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[32] 886 F.2d 182, 186 (8th Cir. 1989).

[33] *Id.* Although *Baxter* was decided under the test used by this Court prior to *Miller*, that test (based on the so-called McCarran-Ferguson factors) focused on "whether the law has the effect of transferring or spreading a policyholder's risk," and the only difference between the two is that the prior test "asked whether the statute in question 'transfers or spreads the risk from the insured to insurer.'" *Provident Life & Accid. Ins. Co. v. Sharpless*, 364 F.3d 634, 640 (5th Cir. 2004). In the context of this case, the difference between the two tests is not significant.

[34] *See Kidneigh v. Unum Life Ins. Co.*, 345 F.3d 1182, 1187 (10th Cir. 2003) (recognizing that the risk at issue is "the risk borne by insurers and the insured"), *cert. denied*, 540 U.S. 1184 (2004).

"risk" is the risk that a plan beneficiary may become injured, and will need medical treatment; the ERISA plan contractually agrees to pay for that treatment. The benefit terms of the ERISA plan define the scope of the plan's acceptance of that risk — a plan may, for example, provide for 100% coverage, for a lesser percentage, for a certain copayment, or for a wide variety of different terms that modify the risk. But, essentially, the plan accepts some or all of the risk that the beneficiary will need medical treatment for which someone has to pay. The Eighth Circuit correctly held in *Baxter* that antisubrogation laws only impact the risk of "double recovery" (an insured's ability to recover for expenses that it did not incur), which "bears no relation to the risk insured against" even though it "may raise the premiums paid for coverage."[35]

Unlike benefit mandates or any-willing-provider statutes, antisubrogation provisions do not increase the probability that the insured will be able to access covered services. Antisubrogation provisions only impact disputes that arise long after coverage has been provided. To be sure, Directive 175 affects the relationship between the beneficiary and the plan, but no matter what may happen in the subrogation arena, the beneficiary's medical providers will be paid, and there is no risk the beneficiary will not be able to obtain medical treatment because he or she cannot pay for it. At most, Directive 175 addresses the remedial issue of who bears the risk that, if a suit is ever commenced against a third party tortfeasor, there will be an

[35] *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F.Supp.2d 296, 306 (E.D. Pa. 2003) (holding that Pennsylvania's Insurance Bad Faith statute did not fall within the savings clause).

insufficient pool of money available. But this occurs long after the beneficiary's medical bills have been paid; this kind of remedial provision does not affect the bargain struck between the beneficiary and the plan for the plan to pay the beneficiary's expenses.

B. Even if Directive 175 were not preempted, it would be invalid as a matter of federal law because it is an improperly issued state regulation purporting to supply a rule of decision for ERISA plans.

Even if Directive 175 were not preempted by ERISA's twin preemption provisions, the Fifth Circuit erred by failing to address whether Directive 175 is invalid as a state regulation that supplies a federal rule of decision. Despite the Commissioner's idiosyncratic views, Directive 175 does not accurately reflect Louisiana law, and should not be applied to a federal ERISA plan.

The Fifth Circuit avoided substantive consideration of this issue by finding that it was raised for the first time in Benefit Recovery's motion to alter or amend in the district court after summary judgment had been rendered against it. This was error. In point of fact, Benefit Recovery had always argued that Directive 175 was an invalidly issued state regulation, and the reply memorandum simply expanded on this argument by arguing that, as an invalidly issued state regulation, it could not be valid as a federal rule of decision. As noted above, the only argument presented to the district court on summary judgment was that of preemption under § 1144. By dismissing *sub silentio* Benefit Recovery's attack on the substantive underpinnings of Directive

175, the district court erred; and by refusing to consider the substantive merits of this argument, the Fifth Circuit erred as well.

Because Directive 175 purports to limit rights under ERISA plans, its interpretation and validity is a federal issue. In *Unum Life Ins. Co. v. Ward*,[36] this Court addressed the California state "notice prejudice" rule, which provided that an insurance company could not deny benefits on the basis of a late notice of a claim unless it proved actual prejudice. The defendant insurer argued that ERISA preempted "any action for plan benefits brought under state rules such as notice-prejudice." The Court determined that the state notice-prejudice rule supplied "the relevant rule of decision" under ERISA.[37] So too in this case does Directive 175, if valid, supply the relevant rule of decision under federal law,[38] and the lower courts should have examined whether, as a matter of federal law, Directive 175 could validly limit an ERISA plan's rights.

Had the Fifth Circuit examined the validity of Directive 175 as a matter of surrogate federal law, it would have readily seen that Directive 175 was issued without any legal authority. Directive 175 contains amorphous and mysterious references to Louisiana

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[36] 526 U.S. 358 (1999).

[37] *Id.* at 377.

[38] *Fink v. Dakotacare*, 324 F.3d 685, 689 (8th Cir. 2003); *Sutherland v. United States Life Ins.*, 263 F. Supp. 2d 1065, 1074 (E.D. La. 2003).

public policy, but nowhere bothers to identify how the Commissioner concluded that Louisiana governing law required the use of the make-whole doctrine or required an ERISA plan to share in the beneficiary's attorney fees. The Commissioner, despite his self-importance, is not the Louisiana legislature, and the law is not what he simply directs that it is. More is needed to effectuate the wide-ranging and immensely significant change he has wrought in Louisiana insurance law.

Conclusion

ERISA can be a frustrating statute to understand and apply. But if its preemption provisions mean anything, they stand for the proposition that a state insurance commissioner cannot dictate terms to an ERISA plan by forcing those terms to be included in the plan documents when the state legislature itself could not even accomplish the same result by positive legislation. Had Louisiana, by law, tried to make ERISA plans include the make-whole and attorney-fee-payment provisions of Directive 175, its law would have been preempted under a long line of precedent from this Court. The commissioner cannot be permitted slyly to do the very same thing through the expediency of the prerogative of his office, but if the Fifth Circuit's decision is left uncorrected, every insurance commissioner will be able to circumvent ERISA in the same way. Accordingly, Benefit Recovery respectfully prays that this Court grant its petition for certiorari.

Respectfully submitted,

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APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT FILED MARCH 11, 2008

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 07-30414

BENEFIT RECOVERY, INC.,

Plaintiff-Appellant,

v.

JAMES J. DONELON,
In His Official Capacity as Commissioner of Insurance for the State of Louisiana,

Defendant-Appellee.

Appeal from the United States District Court for Middle District of Louisiana.

Before REAVLEY, SMITH and DENNIS, Circuit Judges.

JERRY E. SMITH, Circuit Judge:

Benefit Recovery, Inc. ("Benefit"), sued the Louisiana Commissioner of Insurance in his official capacity;[1] the district court granted summary judgment

1. James J. Donelon replaced J. Robert Wooley as Commissioner in 2006 and was substituted as the proper party defendant.

for the Commissioner, holding that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* , does not preempt Directive 175, which the Commissioner had issued. We affirm.

I.

In early 2003, the Commissioner issued Directive 175, which provides that "any right of recovery from third parties on the part of the insurer, whether by subrogation or reimbursement, is subordinate to the insured's right to be fully compensated for his damages; and . . . the insurer is obligated to share in the legal expenses incurred." According to stipulated facts, Directive 175 applies only to insurance policies, not self-funded ERISA benefit plans or entities acting as "pure administrators" of such plans.

Directive 175 therefore encapsulates the so-called "make whole" and *Moody* doctrines. The "make whole" doctrine is "an insurance principle which mandates that, in the absence of contrary agreement, an insurance company may not enforce its subrogation rights until the insured has been fully compensated for her injuries-'made whole.' " *Roberts v. Richard*, 743 So.2d 731, 733 (La.App. 3d Cir.), *writ denied*, 749 So.2d 677 (La.1999). The *Moody* doctrine is that a benefits provider may be "charged with a proportionate share of the reasonable and necessary costs of recovery, including attorneys' fees, incurred by the injured worker in the suit against the third person." *Moody v. Arabie*, 498 So.2d 1081, 1083 (La.1986).

Appendix A

Benefit provides subrogation services to Louisiana self-funded and fully insured employer health benefit plans, many of which are governed by ERISA. A proposed health insurance form from Ochsner Health Plan, with whom Benefit had contracted for subrogation services, was rejected for failing to include terms pursuant to Directive 175.

Benefit sued the Commissioner in August 2003 on the theory that ERISA preempts Directive 175. The parties proposed the case be decided on cross-motions for summary judgment and filed joint stipulations of fact. The district court granted the Commissioner's summary judgment motion on the theory that Directive 175 is saved from preemption by 29 U.S.C. 1144(b)(2)(A) ("Section 514").

Benefit moved to alter or amend the judgment pursuant to Federal Rule of Civil Procedure 59(e), asking the court to decide whether Directive 175 is invalid on state-law grounds and requesting an opportunity to submit additional evidence on the savings clause analysis. The district court refused.

Appendix A

II.

Benefit first contends that ERISA's complete preemption provision, 29 U.S.C. § 1132(a) ("Section 502"), preempts Directive 175. Benefit, however, has not preserved that issue for appeal.

We will not consider arguments or evidence that was not presented to the district court. *Nissho-Iwai Am. Corp. v. Kline*, 845 F.2d 1300, 1307 (5th Cir.1998). Raising an argument in the district court is therefore the essential predicate for a valid appeal. *FDIC v. Mijalis*, 15 F.3d 1314, 1327 (5th Cir.1994). But, we require a party to do more than just raise an argument; the contention must be pressed so that the district court has an opportunity to rule on it. *Id.*

Benefit's motion for summary judgment makes explicit that the issue is whether Section 514 preempts Directive 175. The question whether Section 502 preempts the Directive is therefore presented for the first time on appeal, so we do not reach the merits of Benefit's claim.

Realizing this hurdle, Benefit seeks to invoke our appellate power through a back door: In its reply brief, it urges that parties do not expect cross-motions for summary judgment to end their case.[2] Regardless of the legal merits of such an expectation, Benefit has waived our review of the dismissal of the case, because arguments cannot be raised for the first time in a reply brief. *Yohey v. Collins*, 985 F.2d 222, 225 (5th Cir.1993).

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2. Benefit relies on 10A Charles A. Wright *et al.*, Federal Practice and Procedure § 2720 (2d ed.1995).

Appendix A

III.

Benefit contends Directive 175 is invalid as a matter of federal law because it is an improperly issued state regulation purporting to supply a rule of decision for ERISA plans. We do not reach the merits of that argument, because Benefit raised it only after entry of judgment.

Benefit made the argument for the first time in its unsuccessful rule 59(e) motion. We review for abuse of discretion. *Coliseum Square Ass'n v. Jackson*, 465 F.3d 215, 247 (5th Cir.2006), *cert. denied*, __ U.S. __, 128 S.Ct. 40, 169 L.Ed.2d 11 (2007). In other words, we are not deciding whether Directive 175 is in fact invalid as a matter of federal law, but whether the district court acted improperly.[3]

In denying Benefit's motion, the district court properly relied on *Elementis Chromium L.P. v. Coastal States Petroleum Co.*, 450 F.3d 607 (5th Cir.2006), in which we said that "[m]otions to alter or amend judgments 'cannot be used raise arguments which could, and should, have been made before judgment issued' and 'cannot be used to argue a case under a new legal

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3. *See Walker v. Bank of Am. Nat'l Trust & Sav. Ass'n*, 268 F.2d 16, 25 (9th Cir.1959) (stating that "an order denying a motion made under Rule 59(e) to alter or amend a judgment is appealable, but only on the question whether there has been a manifest abuse of discretion"), *overruled on other grounds*, *Cohen v. Norris*, 300 F.2d 24 (9th Cir.1962); *see also* 11 Wright & Miller, *supra*, § 2818.

theory.' " *Id.* at 610 (quoting *Simon v. United States*, 891 F.2d 1154, 1159 (5th Cir.1990)).

Throughout its submissions to the district court, Benefit relied on a theory of ERISA preemption. When the district court found that argument unavailing, Benefit presented the new argument. The district court did not abuse its discretion in refusing to change its judgment in response to Benefit's motion.

IV.

Benefit contends that ERISA's conflict preemption section, 29 U.S.C. § 1144(a) ("Section 514"), preempts Directive 175. Section 514 "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." § 1144(a). The preemption is not complete, however, because ERISA saves "any law of any State which regulates insurance, banking, or securities." § 1144(b)(2)(A).

The initial question is whether Directive 175 is a "State law" such that it falls within the preemptive scope of Section 514(a). ERISA defines a "State law" as "all laws, decisions, rule, regulations, or other State action having the effect of law, of any State." § 1144(c).

It is somewhat difficult to categorize Directive 175. In Louisiana, a directive is a "written communication or order issued by or on behalf of the commissioner of insurance to a person whose activities are regulated by this Title, which instructs the person to act in

conformance with this Title, or any rule or regulation adopted in accordance with the Administrative Procedure Act." La.Rev.Stat. Ann. § 22:5(6) (2004). In other words, to the extent that directives have the "effect of law," it is because they merely expound on what is already in the insurance code. At the same time, there are punitive consequences for violating a directive.[4] There is no need for us to engage in a metaphysical inquiry into the nature of "law" or its effects where the hand of the state firmly, though not harshly, requires compliance.

There can be no doubt that if Directive 175 is a "State law," it falls within the preemptive scope of Section 514. The other requirement for preemption is that the state law must "relate to" insurance. Not only has the Supreme Court read this prong expansively, *see, e.g. Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987), but it is intuitively correct that regulating insurance contracts means regulating insurance.

Our inquiry does not end with the preemption prong; we must determine whether the state law is saved because it regulates insurance. To decide whether a state law regulates insurance, it must (1) be specifically

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4. *See, e.g.*, La.Rev.Stat. Ann. § 22:1316(A) (2004) ("Any person subject to the regulatory authority of this department who fails to comply with any directive issued by the commissioner in connection with a consumer complaint shall be fined an amount not to exceed two hundred fifty dollars for each occurrence.").

directed toward entities engaged in insurance and (2) substantially affect the risk pooling arrangements of insurer and insured. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003).

Benefit's first argument is that although Directive 175 is a "State law" as used in Section 514(a), it is not a "law of any State" as used in Section 514(b). The argument encompasses the not-absurd proposition that the savings clause must be narrower than the preemption clause. It is undeniable that Congress employed different verbal formulations in the respective two sections. Whatever its intuitive merits, however, the argument fails.

We conclude that any "State law" as defined in the preemption provision qualifies as the "law of any state" for the purposes of the savings clause. The savings clause was phrased with "similar breadth" as the preemption clause. *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 363, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999). The Court observed this in the process of holding that a judicially created "notice-prejudice" rule regulated insurance and therefore was saved from preemption. *Id.* at 367-72, 119 S.Ct. 1380. If a judicial rule can be a state law, it is far from certain where we would draw the dividing line between "State laws" and "laws of any State."[5] Given the similar breadth of the clauses, if

5. Even outside the ERISA context, this is correct in light of the discrediting of the distinction between state statutes and judicial decisions as expressed in *Swift v. Tyson*, 41 U.S. 1, 16 Pet. 1, 10 L.Ed. 865 (1842).

statutes and state supreme court decisions are "State laws," it follows that rules, regulations, and anything else having the effect of law are as well.

Nor is there a problem with the exception's swallowing the rule. State laws need only "relate to" insurance to fall within ERISA preemptive scope;[6] only those laws that regulate insurance are saved. We therefore decline to extend the test set out in *Miller* by effectively adding a new requirement—distinguishing "State laws" from "laws of any State."

Pursuant to *Miller*, *id.* at 341-42, 123 S.Ct. 1471, our inquiry is whether Directive 175 is specifically directed toward entities engaged in insurance and substantially affects the risk pooling arrangements of insurer and insured. There can be no question that Directive 175 is specifically directed toward entities engaged in insurance, because it specifically requires insurance companies to include certain terms in their contracts.[7]

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6. Benefit cites numerous cases for the proposition that the savings clause must be read more narrowly that the preemption clause. That is obviously correct. Benefit does not appreciate, however, that the narrowing occurs because the savings clause speaks to only a narrow class of laws, namely those that "regulate insurance" and not merely "relate to" it. *See e.g.*, *Suggs v. Pan Am. Life Ins. Co.*, 847 F.Supp. 1324, 1347 (S.D.Miss.1994).

7. *See Rush Prudential v. Moran*, 536 U.S. 355, 365-66, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (determining whether a law that "regulates insurance" requires that "we start with a 'common-

(Cont'd)

The only substantial question is whether the Directive substantially affects the risk pooling arrangement of insurer and insureds. Benefit argues that the "risk pooling" at issue is different from that identified in *Miller*, in which the Court determined that an "any willing provider" requirement, which prevented discrimination against any provider willing to meet the terms and conditions in the ERISA plan, was not preempted. *Id.* at 338, 123 S.Ct. 1471.

In *Miller*, *id.* at 339, 123 S.Ct. 1471, the Court read the second prong to apply whenever a law "alters the scope of permissible bargains between insurers and insureds." Directive 175 certainly alters the permissible bargains between insurers and insureds by telling them what bargains are acceptable.[8] Accordingly, the Directive affects "risk pooling" and is therefore saved from Section 514 preemption.

AFFIRMED.

(Cont'd)
sense view of the matter,' . . . under which 'a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry' ") (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987)).

8. Our caselaw supports such an understanding. In *Ellis v. Liberty Life Assur. Co.*, 394 F.3d 262, 277 (5th Cir.2004), we held that two Texas statutes that provided causes of action for insureds when insurers acted in bad faith were preempted by ERISA. Because the two statutes were remedial, they could not "possibly affect the bargain that an insurer makes with its insured *ab initio*." *Id.* The statutes therefore applied regardless of the bargain struck.

Directive 175 is different. It sets out, *ab initio*, what terms are acceptable in insurance contracts. This is the precise distinction we drew in *Ellis*.

APPENDIX B — RULING OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF LOUISIANA DATED AND FILED APRIL 11, 2007

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

CIVIL ACTION NO.
03-652-JJB-DLD

BENEFIT RECOVERY

VERSUS

J. ROBERT WOOLEY, IN HIS CAPACITY AS COMMISSIONER OF INSURANCE OF THE STATE OF LOUISIANA

RULING ON PLAINTIFF'S MOTION TO ALTER OR AMEND JUDGMENT

This matter is before the court on a Motion to Alter or Amend Judgment filed by the plaintiff, Benefit Recovery, Inc. (doc. 63). A memorandum in opposition has been filed by defendant, James J. Donelon, in his capacity as Commissioner of Insurance for the State of Louisiana (doc. 66).

Background

This court was presented with Cross Motions for Summary Judgment filed by the parties. On December 5, 2006, this court issued a Ruling granting the Defendant's Motion for Summary Judgment (doc. 61).

The plaintiff now seeks to have this court alter or amend its prior ruling. The relevant background facts in this matter were laid out in this Court's Ruling on the Motions for Summary Judgment (doc. 61), and are therefore incorporated herein.

Standard of Law

A Rule 59(e) Motion serves the narrow purpose of "[calling] into question the correctness of a judgment," and is invoked "to correct manifest errors of law or fact or to present newly discovered evidence." *In re Transtexas Gas Corp.*, 303 F. 3d 571, 581 (5th Cir. 2002). The Fifth Circuit Court has clarified that Rule 59(e) Motions "cannot be used to raise arguments which could, and should, have been made before the judgment issued" and "cannot be used to argue a case under a new legal theory." *Elementis Chromium L.P. v. Coastal States Petroleum*, 450 F.3d 607, 610 (5th Cir. 2006) (quoting *Simon v. U.S.*, 891 F.2d 1154, 1159 (5th Cir. 1990)).

Analysis

I. Summary of the Arguments

The Plaintiff offers two reasons why this court should amend its prior judgement. First, the plaintiff disputes this court's "determination that Benefit Recovery could not challenge whether Directive 175 contravenes Louisiana law." Second, the plaintiff desires the court to reexamine "whether Directive 175 satisfied

the factors announced in *Kentucky Ass'n of Health Plans v. Miller*,[1] which govern whether a state law falls within the ERISA savings clause."

The defendant argues that the plaintiff's claims amount to new or modified legal theories and are insufficient to warrant an amended judgment under Rule 59(e). The defendant further argues that because the parties agreed that the matters would be submitted on summary judgment, the plaintiff should have submitted all evidence addressing the savings-clause analysis.

II. ERISA preemption

In reviewing the pleadings submitted by the plaintiff in the Cross Motions for Summary Judgment, the plaintiff argued several reasons why Directive 175 should not be enforced. First, the plaintiff argued that Directive 175 did not have the force of law.[2] Second, that Directive 175 was preempted by ERISA.[3] Third, that Directive 175 violated the Contract Clause of the United States Constitution.[4]

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1. 538 U.S. 329 (2003).

2. *See, e.g.*, Doc. 58 (Memorandum in Opposition, p.6).

3. Doc. 52 (Plaintiff's Memorandum in Support of Motion for Summary Judgment, p. 5). Plaintiff states that its primary argument was that Directive 175 was preempted.

4. Doc. 52 (Plaintiff's Memorandum in Support of Motion for Summary Judgment, p. 5).

Appendix B

In its December 5, 2006 ruling, this court rejected each of the plaintiff's arguments. First, this court found that Directive 175 was a state law that was directed toward entities engaged in insurance.[5] Second, this court concluded that Directive 175 was not preempted by ERISA because it was a "saved statute."[6] Third, this court ruled that Directive 175 did not violate the Contract Clause of the United States Constitution.[7]

Now in its Rule 59(e) Motion, the plaintiff argues that the ERISA preemption and savings clause analysis need not have been reached because Directive 175 did not accurately depict the law of the state of Louisiana. This court agrees with the defendant that this attempt to link the dismissed state law claims to the ERISA preemption analysis is a new legal argument that cannot be urged under Rule 59(e). Throughout its prior submissions to the court, Benefit Recovery has relied on a theory of ERISA preemption. Now that this court has ruled against it, the plaintiff attempts to advance a different legal theory. As previously stated Rule 59(e) "cannot be used to argue a case under a new legal theory."

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5. Doc. 61 (Ruling on Cross Motions for Summary Judgment, p. 9).

6. Doc. 61 (Ruling on Cross Motions for Summary Judgment, p.14 -19).

7. Doc. 61 (Ruling on Cross Motions for Summary Judgment, p. 20).

Appendix B

III. *Savings Clause Analysis - (Miller test)*

The plaintiff's second argument in favor of altering or amending the court's judgment is its contention that "the court committed manifest error of law in applying the *Miller* factors without permitting Benefit Recovery to present evidence that they were not satisfied."[8] The defendant contends that this argument is without merit. It asserts that the saving clause analysis set forth in *Miller* was discussed in the plaintiff's submissions to the court and the plaintiff had ample opportunity to present evidence to the court.

This court is not persuaded by the plaintiff's arguments that it was not "permitt[ed]" to present evidence pertaining to the savings clause analysis. In reviewing the plaintiff's prior submissions to the court, it is evident that the plaintiff argued that Directive 175 was not a saved statute.[9] In its prior memorandum, the plaintiff correctly cited *Miller* and then offered reasons why Directive 175 could not satisfy the *Miller* criteria.[10] The plaintiff stated that "Directive 175 cannot satisfy

8. Doc. 64 (Memorandum in Support of Plaintiff's Motion to Alter or Amend Judgment, p. 8).

9. Doc. 52 (Plaintiff's Memorandum in Support of Motion for Summary Judgment, p. 6).

10. *See* Doc. 61 (Ruling on Cross Motions for Summary Judgment, p. 7). *Miller* sets out a two-pronged test. First, the state law must be specifically directed toward entities engaged in insurance. Second, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

the first criteria of *Miller* because, by the DOI's own admission, it is not a law. Moreover, because Directive 175 does not substantially affect the risk pooling arrangement between insurer and insured, it fails to satisfy the second *Miller* criteria."[11] The plaintiff relied on *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989) for the proposition that Directive 175 did not substantially affect the risk pooling arrangement between the insurer and the insured.

In its prior ruling this court considered the plaintiff's arguments and found that the plaintiff's reliance on *Baxter* was inappropriate. Among other things, this court noted that *Baxter* was decided using the old McCarran-Ferguson factors, not the current *Miller* factors.[12] In rendering its decision, this court relied upon cases applying the *Miller* factors and ultimately concluded that Directive 175 substantially affected the risk-pooling arrangement between the insured and the insurer.

Now presented with a ruling against it, the plaintiff argues that it was not permitted to present evidence regarding the *Miller* factors. It must be remembered that this matter was before the court on Cross Motions for Summary Judgment. It was the obligation of the parties to present competent evidence and to direct the

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11. Doc. 52 (Plaintiff's Memorandum in Support of Motion for Summary Judgment, p. 8).

12. Doc. 61 (Ruling on Cross Motions for Summary Judgment, p. 16).

court to evidence in the record supporting their respective positions. As previously discussed, the plaintiff was acutely aware of *Miller* and the proper savings clause analysis. The fact that the plaintiff relied upon outdated case law or the fact that the plaintiff did not offer additional evidence to support its position is insufficient to warrant a Rule 59(e) Motion.

CONCLUSION

For the reasons stated herein, the plaintiff's Motion to Alter or Amend Judgment is hereby DENIED.

Baton Rouge, Louisiana, April 11th, 2007.

s/ James J. Brady
JAMES J. BRADY
UNITED STATES DISTRICT JUDGE

APPENDIX C — RULING OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF LOUISIANA DATED AND FILED DECEMBER 5, 2006

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

CIVIL ACTION NO.
03-652-JJB-DLD

BENEFIT RECOVERY

VERSUS

J. ROBERT WOOLEY, IN HIS CAPACITY AS COMMISSIONER OF INSURANCE OF THE STATE OF LOUISIANA

RULING ON CROSS MOTIONS FOR SUMMARY JUDGMENT

This matter is before this court on a Motion to Dismiss, or in the Alternative, Motion for Summary Judgment filed by the defendant (doc. 46). The plaintiff, Benefit Recovery, Inc., filed a memorandum in opposition (doc. 58). The defendant has filed a reply memorandum in support of its position (doc. 60).

The plaintiff has also filed a Motion for Summary Judgment (doc. 49). The defendant has filed a memorandum in opposition (doc. 55). The plaintiff has filed a reply memorandum in support of the motion (doc. 59). This court has jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

Appendix C

BACKGROUND FACTS

The plaintiff, Benefit Recovery, Inc. provides subrogation services to Louisiana self-funded and fully insured employer health benefit plans, many of which are governed by the Employee Retirement Income Security Act (ERISA).

On January 8, 2003, the Commissioner of Insurance issued Directive 175, which states in pertinent part that, "any right of recovery on the part of the insurer, whether by subrogation or reimbursement, is subordinate to the insured's right to be fully compensated for his damages, and that the insurer is obligated to share in the legal expenses incurred."

Directive 175 encapsulates the "make whole" doctrine and the *Moody* doctrine. The "Make Whole" doctrine is "an insurance principle which mandates that, in the absence of a contrary agreement, an insurance company may not enforce its subrogation rights until the insured has been fully compensated for her injuries - 'made whole.' "[1] Under the *Moody* doctrine, a benefits provider may be "charged with a proportionate share of the reasonable and necessary costs of recovery, including attorneys' fees, incurred by the injured worker in the suit against the third person."[2]

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1. *Roberts v. Richard*, 743 So. 2d 731, 733 (La. App. 3 Cir. 1999).

2. *See Moody v. Arabie*, 498 So. 2d 1081, 1083 (La. 1986) (amended by La. R.S. 23:1103).

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The plaintiff alleges that prior to January 8, 2003, the Department of Insurance routinely allowed health plans paying for the treatment of accidental injuries to contract around the Make Whole and *Moody* doctrines. However, after the issuance of Directive 175, contracting around the doctrines is no longer permitted.

Benefit Recovery sued J. Robert Wooley[3] alleging that Directive 175 was outside the scope of the Commissioner of Insurance's authority and that Directive 175 was preempted by the Employers Retirement Income Security Act (ERISA). The plaintiff seeks a declaration that Directive 175 is preempted by ERISA and an injunction.

STANDARD OF LAW

Summary judgment is appropriate when the pleadings, answers to interrogatories, admissions, and affidavits on file indicate that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986).

When the burden at trial rests on the non-movant, the movant need only demonstrate that the record lacks sufficient evidentiary support for the non-movant's case.

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3. *But see* Doc. 45 (Unopposed Motion to Substitute Party Defendant). The defendant moved to have James J. Donelon substituted as defendant after he succeeded J. Robert Wooley as Commissioner of Insurance. The motion was granted on July 5, 2006 (doc. 50).

Id. The movant may do this by showing that the evidence is insufficient to prove the existence of one or more elements essential to the non-movant's case. *Id.*

Although this court considers the evidence in the light most favorable to the non-movant, the non-movant may not merely rest on allegations set forth in the pleadings. Instead, the non-movant must show that there is a genuine issue for trial. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986). Conclusory allegations and unsubstantiated assertions will not satisfy the non-movant's burden. *Grimes v. Dep't of Mental Health*, 102 F.3d 137, 139-40 (5th Cir. 1996). If once the non-movant has been given the opportunity to raise a genuine factual issue, no reasonable juror could find for the non-movant, summary judgment will be granted. *See Celotex*, 477 U.S. at 322; *see also* Fed. Rule Civ. P. 56(c).

ANALYSIS

I. Standing

In a previous ruling in this case, this court decided that Benefit Recovery had standing to pursue this action under Article III. (doc. 17). Specifically, this court ruled that Benefit Recovery had alleged a concrete and immediate injury that was redressable by a favorable court decision.

In its latest motion, the defendant re-urges the issue of standing. This time, however, the defendant argues

that even if the plaintiff has Article III standing, the plaintiff lacks prudential standing and so the matter should be dismissed.

The defendant correctly points out that the federal standing doctrine has two components. The first, Article III standing, which the court has already ruled upon, addresses the Constitution's case and controversy requirement. The second component is prudential standing which "embodies judicially self-imposed limits on the exercise of federal jurisdiction." *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S.1,11-12 (2004) (quoting *Allen v. Wright*, 468 U.S. 737, 751 (1984)). This court has not yet expressly ruled upon the prudential standing component in this case.

The Supreme Court has explained that "prudential standing encompasses 'the general prohibition on a litigant's raising another person's legal rights, the rule barring adjudication of generalized grievances more appropriately addressed in the representative branches, and the requirement that a plaintiff's complaint fall within the zone of interests protected by the law invoked." *Id.* at 12.

Under the prudential standing doctrine, the Supreme Court has held that generally, a party "must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." *Kowalski v. Tesmer*, 543 U.S. 125, 129 (2004) (quoting *Warth v. Seldin*, 422 U.S. 490, 499 (1975)). Nevertheless, the Supreme Court has stated

that this rule is not absolute and the court has recognized "that there may be circumstances where it is necessary to grant a third party standing to assert the rights of another." *Id.* at 129-30. However, to fall within this exception, a party seeking third party standing must make two additional showings. *Id.* at 30. First, the party asserting the right must have a "close" relationship with the person who possesses the right. Second, there must be a "hindrance" to the possessor's ability to protect his own interests.

In its motion to dismiss, the defendant argues that because Benefit Recovery is not an insurer, it has no legal rights at stake and must rely upon third party standing. The defendant further asserts that even if Benefit Recovery has a "close" relationship with persons who possess the right at issue, Benefit Recovery cannot establish that a "substantial hindrance" prevents insurers from asserting their own rights. In response, the plaintiff incorporates all of the arguments made in its memorandum in opposition to defendant's original motion to dismiss.

In *Burgio & Campofelice, Inc. v. NYS Dep't of Labor*, 107 F.3d 1000 (2d Cir. 1997), the plaintiff argued that the state was enforcing a law that was preempted by ERISA and the Supremacy Clause. In response, the defendants asserted that the plaintiff lacked standing to protest the law because he was not an ERISA plan participant, beneficiary, or fiduciary.

In deciding the matter, the *Burgio* court agreed "with those commentators who have concluded that 'the best explanation of *Ex parte Young* and its progeny is that the Supremacy Clause creates an implied right of action for injunctive relief against state officers who are threatening to violate the federal Constitution or laws.'" *Id.* at 1006. The court further explained that "remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." *Id.*

In this case, the plaintiff is not seeking enforcement of a state law, rather it is challenging the enforcement of the law and its constitutionality. Thus, the plaintiff need not assert third party standing. Accordingly, this court reaffirms that the plaintiff has constitutional standing and also clarifies that the plaintiff has prudential standing.

II. The Preemptive Effect of ERISA upon Directive 175

The scope of ERISA is set out in 29 U.S.C. § 1144. It states in pertinent part that ERISA "shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." However, even if a state statute falls within the preemptive scope of ERISA, it will not be preempted if it is a "saved statute." ERISA's saving clause provides that "except as provided in [the deemer clause][4] nothing in this

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4. The deemer clause states that:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt

(Cont'd)

subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

The Supreme Court has held that for a state law to be classified as a law which "regulates insurance," it must meet a two-pronged test. *Kentucky Assoc. of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003). First, the state law "must be specifically directed toward entities engaged in insurance." Second, the state law must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.*

As a preliminary matter, it is necessary to address whether Directive 175 is preempted as a law that relates to ERISA. ERISA preempts "any and all State laws[5]

(Cont'd)

> under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B).

5. Whether Directive 175 is a "state law" under ERISA is explored in depth in Section II(A) of this opinion.

insofar as they may now or hereafter relate to any employee benefit plan" that is covered by ERISA. 29 U.S.C. § 1144(a).

The defendant appears to argue that Directive 175 is not preempted by ERISA because Directive 175 does not apply to self-funded plans and only applies to fully insured plans.[6] The plaintiff directs the court to *Swerhun v. Guardian Life Ins. Co. of America*, 979 F.2d 195 (11th Cir. 1992). In that case, the appellant argued that the distinction between fully insured and self-funded plans "fundamentally altered the ERISA preemption analysis." However, the *Swerhun* court disagreed, it explained that:

> The Supreme Court addressed this distinction strictly in the context of the interplay between the saving clause and the deemer clause. Because Swerhun's claims are not 'saved' by the saving clause, the deemer clause is immaterial, and her reliance upon the fully insured / self-insured distinction in the Court's deemer clause jurisprudence is misplaced.

Id. at 199, n.6.

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6. *See, e.g.*, Doc. 60 (Reply Memorandum in Support of Defendant's Motion to Dismiss, or in the Alternative, For Summary Judgment, p.2-5).

The court agrees with the plaintiff and finds that at this stage the fully insured and self-funded distinction is immaterial. Accordingly, in this case, the central issue is whether Directive 175 is saved from preemption by ERISA's saving clause.

A) Saving Clause Analysis, Part 1:

Whether Directive 175 is a state law that is directed toward entities engaged in Insurance

Relying upon one of the joint stipulations made by the parties, Benefit Recovery argues that Directive 175 cannot satisfy the first prong of the *Miller* test because the directive is not a "law." In Joint stipulation of Fact Number 2, the parties have stipulated that "directives do not themselves have the force of law, but directives inform insurers as to the position of the Commissioner regarding the law and public policy of Louisiana and instructs insurers of the need to draft their forms in compliance."[7]

In response, the defendant argues that ERISA's saving clause is not limited to statutes. The defendant points to the definition section of ERISA, which states that the term "state law" includes "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State."

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7. Doc. 44-1 (Joint Stipulation and Designation of Exhibits).

Appendix C

In support of its position that Directive 175 is a "state law" as envisioned by ERISA, the defendant cites *Gauthreaux v. USAA Casualty Ins. Co.*, No. 00-2045, 2001 WL 65573 (E.D. La. Jan. 25, 2001). In *Gauthreaux*, a district court held that although a directive issued by the Commissioner of Insurance was "not technically a regulation" the directives were "directed to all insurance companies operating in Louisiana, and compliance with its provisions is mandatory." *Id.* at *2. The court then took judicial notice of the directive as "a matter of public record and as a governing quasi-regulation." *Id.*

In this case, the categorization of the directive issued by the Commissioner of Insurance is not an easy task. A directive is defined by Louisiana Revised Statute 22:5 as a "written communication or order issued by or on behalf of the commissioner of insurance to a person whose activities are regulated by this Title, which instructs the person to act in conformance with this Title, or any rule or regulation adopted in accordance with the Administrative Procedure Act." This does not provide much aid in the classification of a directive.

Additionally, the stipulations in the parties' Joint Stipulation do not resolve the matter. It is true that stipulation of fact 2 states that "directives do not themselves have the force of law." Yet, this must also be paired with stipulation 1 which says that directives "provide a mechanism for [the] enforcement" of the Insurance Code.[8] Moreover, it is not clear that the

8. Doc. 44-1 (Joint Stipulations and Designations of Exhibits; Stipulation of Fact, Number 1).

stipulation that 'directives do not have the force of law' is an accurate reflection of the true nature of a directive. Directive 175 is in effect a mandatory provision because it expressly states that insurers who do not follow the directive "will be subject to sanctions including but not limited to the imposition of such fines as are authorized by law."

Thus, the directives do not appear to fit neatly into any mold. Judge Vance's characterization of a directive as a "quasi-regulation" seems most fitting.[9] Directives instruct insurers; however, they are mandatory and enforced, and those who chose not to follow them can be sanctioned.[10]

This court agrees with the arguments asserted by the defendant. As the defendant aptly pointed out, whether this court treats the Directive as a "quasi-regulation," "a written communication or order," or "some other type of official instrument, it is clear that, at a minimum, Directive 175 is State action that instructs insurers on permitted practices and cautions them about the consequences of non-compliance."[11] This is sufficient

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9. *Gauthreaux*, 2001 WL 65573, at *2.

10. *See, e.g.*, La. R.S. 22:1316(A). It states that "[a]ny person subject to the regulatory authority of this department who fails to comply with any directive issued by the commissioner in connection with a consumer complaint shall be fined an amount not to exceed two hundred fifty dollars for each occurrence." *Id.*

11. Doc. 60 (Defendant's Reply Memorandum in Support of Defendant's Motion to Dismiss, or in the Alternative, For Summary Judgment, p. 6-7).

to satisfy the "state law" requirement of the saving clause analysis.

Additionally, as a practical matter, the plaintiff's argument that Directive 175 is not a "state law" for the purpose of ERISA's savings clause must fail.[12] If this court accepts the premise that Directive 175 is not a "state law" and not subject to ERISA's savings clause, the plaintiff may have won that battle, but it will have lost the war. Arguing that Directive 175 is not a "state law" is a dubious argument that places the plaintiff on unsteady footing and causes a more problematic issue to come to light. The United States Code provides that ERISA's preemptive power applies to "state laws." The term "state law" is defined only once in the ERISA context. Accordingly, if Directive 175 is not a "state law" for the purpose of ERISA's saving clause; it is also not a "state law" that is subject to ERISA preemption. This would make Directive 175 immune from ERISA's reach and there would be no need to even conduct a saving clause analysis.

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12. This court has taken notice of the fact that the plaintiff has made seemingly contradictory arguments about the Directive's status as a "state law." In arguing that the Directive can be preempted by ERISA, the plaintiff urges that "semantics aside, it is clear that the Commissioner enforces Directive 175 and treats it as *having* the force of law." (Doc. 58, p.4) (emphasis added). However, in arguing that ERISA's saving clause analysis does not apply, the plaintiff urges that the directives "do *not* have the force of law." (Doc. 59, p.2) (emphasis added). Thus, the plaintiff's arguments pertaining to whether the directive is a "state law" have varied, depending upon what provides the most advantageous result to the plaintiff.

In essence, for this court to adopt the plaintiff's argument it would have to find that Directive 175 *is* a "state law" such that it can be preempted by ERISA, but it is *not* a "state law" in that it cannot be saved by ERISA's saving clause. As "state law"' has only one definition under ERISA, this court is not prepared to reach such a contradictory result.

Having decided that Directive 175 is a law for the purpose of ERISA's Saving Clause, it is clearly apparent that such a law is directed toward the insurance industry. The plaintiff cites *Levine v. United Healthcare Corp.*, 402 F.3d 156 (3d Cir. 2005) which concluded that a New Jersey statute was not preempted by ERISA because the statute was one of general applicability and was not directed to the insurance industry. However, this court does not find *Levine* to be persuasive under the present facts. In this case, Directive 175 is directed specifically to insurers and was written by the Commissioner of Insurance. It specifically states that the purpose of the directive was to streamline the insurance policy review process and to supplement Regulation 78, an insurance provision.

Accordingly, this court concludes that Directive 175 is a law that is specifically directed toward the insurance industry.

Appendix C

B). Saving Clause Analysis, Part 2:

Whether Directive 175 substantially affects the risk pooling arrangement between the insurer and the insured.

The second prong of the Saving Clause analysis requires that the state law "substantially affect the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 342. The plaintiff cites *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989), in support of its position that Directive 175 does not substantially affect the risk pooling arrangement between an insurer and the insured.[13] The plaintiff relies upon language in *Baxter* in which the court stated that "the practice of subrogation does not transfer the risk from a policyholder to his or her insurer. Rather it limits the recovery available to the policyholder by preventing a double recovery."

In response, the defendant argues that *Baxter* should not be relied upon because *Baxter* was decided before *FMC* Corp[14] and *Miller* and is not in accord with current jurisprudence.

Prior to *Miller*, the Saving Clause analysis was governed by the McCarran-Ferguson factors. These factors were: 1) whether the practice has the effect of

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13. Doc. 52 (Plaintiff's Memorandum in Support of Motion for Summary Judgment).

14. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

transferring or spreading a policyholder's risk; 2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and 3) whether the practice is limited to entities within the insurance industry. *Miller*, 538 U.S. at 333.

The Supreme Court, however, came to the conclusion that the McCarran-Ferguson analysis had "misdirected attention, failed to provide clear guidance to lower federal courts" and had "added little to the relevant analysis." *Id.* at 339-40. The court then declared that it was making "a clean break" from the McCarran-Ferguson factors and adopted the two part Miller analysis discussed above. *Id.*

Courts have found that *Miller* has "dramatically changed the analysis for determining whether state legislation qualifies for exemption from express preemption under ERISA via ERISA's saving clause." *Stone v. Disability Mgmt. Servs., Inc.*, 288 F. Supp. 2d 684, 693 (M.D. Pa. 2003) (quoting *Rosenbaum v. Unum Life Ins. Co.*, No. 01-6758, 2003 WL 22078557 (E.D. Pa. Sept. 8, 2003)).

Specifically, in *Stone*, the court explained that "it is critically important to note the difference between the second prong of the *Miller* test and the first of the now defunct McCarran-Ferguson factors which asks 'whether the [law] has the effect of transferring or spreading a policyholder's risk." *Id.* at 693-94. Thus, the focus of the old test (McCarran-Ferguson) was on the transfer and spreading of the risk. The new test (Miller),

however, speaks in terms of substantially affecting the risk pooling arrangement.

In this case, the plaintiff urges this court to rely on the Eighth Circuit's holding in *Baxter* that "the practice of subrogation does not transfer the risk from a policyholder to his or her insurer." 886 F.2d at 186. However, the plaintiff's argument suffers from several deficiencies. First, the plaintiff failed to point out that at least one other circuit court had reached a different conclusion from *Baxter* and held that the practice of disallowing subrogation clauses *does* transfer the policyholder's risk. *See United Food v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986). The plaintiff does not attempt to distinguish *United Food* nor does the plaintiff offer any explanation as to why this court should follow *Baxter* instead.

Second, even assuming that Baxter correctly decided the matter, *Baxter* was decided using the McCarran-Ferguson factors, not the current Miller factors. The two tests are not the same. Therefore, a state law that does not spread the policyholder's risk can *still* substantially affect the risk pooling arrangement. *See Miller*, 538 U.S. at 339, n.3 (distinguishing McCarran-Ferguson from Miller and concluding that although the state law at issue did not spread the policyholder's risk, it did substantially affect the risk pooling arrangement). *See also Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1145 (9th Cir. 2003) (concluding that current risk-pooling jurisprudence offers a potentially broader concept of risk allocation than earlier precedent suggested).

Appendix C

One recent case, decided by a federal district court offers a persuasive analysis of whether subrogation substantially affects the risk pooling arrangement under the current rubric established by *Miller*. In *Smith v. Life Ins. Co. of N. America*, No. 05-2215, 2006 WL 2842529 (N.D. Ga. Sept. 28, 2006), the plaintiff suffered a debilitating injury due to a car accident. The plaintiff reached a monetary settlement with the driver and the driver's employer for $5 million. The defendant, an insurance provider of Long Term Disability plans, was required to provide benefits to the plaintiff during the disability. The defendant argued that it should have a set-off of the settlement amount and it reduced the amount of the plaintiff's benefits. The plaintiff countered that because his future medical expenses would be in the $1 million to over $5 million range and because his loss in earnings would exceed $14 million, he had not been made whole by the third party settlement. Therefore, the plaintiff argued that the make whole doctrine precluded any offset of the settlement. *Id.* at *1-3.

In deciding the matter, the district court examined Georgia's anti-subrogation provision.[15] The statute provided that "the benefit provider may require reimbursement only if the amount of recovery exceeds the sum of all economic and non-economic losses

15. The district court concluded that under federal common law the make whole doctrine applied. However, it included the discussion of Georgia's anti-subrogation statute as an alternative grounds for reaching its conclusion. *Smith*, 2006 WL 2842529, at *14, n.9.

incurred as a result of the injury" (Make Whole doctrine) and it provided that "the amount of the reimbursement claim must be reduced by the pro rata amount of attorney's fees and the expenses of litigation incurred by the injured party" (*Moody* doctrine). *Id.* at *10.

In examining whether the statute was preempted by ERISA, the *Smith* court was directed by the Supreme Court's two-pronged *Miller test.* After finding that the law was directed toward the insurance industry, the court turned to the issue of whether Georgia's anti-subrogation statute substantially affected the risk pooling arrangement between the insurer and the insured. *Id.* at *14-15. The court concluded that:

> Georgia's anti-subrogation statute also satisfies the second prong of the Supreme Court's test, as it affects the risk pooling arrangement between the insurer and the insured. The statute specifically controls the terms of insurance policies by rendering unenforceable policies and contracts, which contain or incorporate provisions in conflict with the Code. Because the state law controls the actual terms of the insurance policies, it is a prime example of a law that substantially affects the risk-pooling arrangement between the insured and the insurer.

Id. at *14.

In this case, like the Georgia anti-subrogation statute, Directive 175 incorporates the *Moody* and Make Whole doctrines. Therefore, this court finds that *Smith* sheds persuasive light on the matter currently before this court.

The holding in *Smith* is further bolstered by language by the Supreme Court in *Miller.* 528 U.S. 329. In *Miller* the court was called upon to examine an Any Willing Provider statute ("AWP"), which mandated that an insurer could not discriminate against a provider located within the geographic area of the plan and willing to meet the conditions for participation. *Id.* at 332-33. The petitioner argued that the AWP statutes did not substantially affect the risk pooling arrangement because they did not alter or affect the terms of insurance policies and only pertained to the relationship between insureds and third-party providers. *Id.* at 338. The Supreme Court concluded that:

> we have never held that state laws must alter or control the actual terms of insurance policies to be deemed 'laws . . . which regulat[e] insurance' under [the saving clause]; it suffices that they substantially affect the risk pooling arrangement between insurer and insured. By expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds . . .

Id.

In the instant case, Directive 175 not only affects the risk pooling arrangement, but it also controls the actual terms of insurance policies. Insurers are no longer able to contract out of the Make Whole doctrine or the *Moody* doctrine and attempts around it are treated as if they were not written. Thus, Directive 175 alters the scope of permissible bargains between insurers and insureds. This court agrees with *Smith* that anti-subrogation laws, such as the one at issue in this case, substantially affect the risk-pooling arrangement between the insured and the insurer.

Although it may be true that anti-subrogation laws do not transfer or spread the risk,[16] as previously discussed, that is no longer the inquiry and the plaintiff's reliance upon cases that explore whether such statutes spread or transfer the risk is misguided.

III. The Contract Clause and Directive 175

The plaintiff has alleged that Directive 175 "violates the Contracts Clause of the Louisiana and United States Constitutions, in that it attempts to invalidate provisions that health benefits plans have the contractual freedom to enact."[17]

In its motion for summary judgment, the defendant argues that Directive 175 does not violate the Contracts

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16. *But cf. United Foods*, 801 F.2d at 1161 (finding that an anti-subrogation statute did transfer the risk).

17. Doc. 1 (Plaintiff's Original Complaint for Declaratory and Injunctive relief, par. 16).

Clause because: 1) Directive 175 did not change the law; 2) even if Directive 175 changed the law, the directive only applies prospectively and would not affect existing contracts; and 3) even if Directive 175 did change the law and substantially impaired existing contractual rights, the Commissioner issued Directive 175 for a legitimate public purpose.[18] The plaintiff did not respond to the Contracts Clause issue in its Memorandum in Opposition to the defendant's motion, nor did the plaintiff address the Contracts Clause issue in its own Motion for Summary Judgment. Accordingly, the plaintiff has not offered any explanation or citation to any authority to support its position that Directive 175 is in violation of the Contract Clause.

The United States Constitution states that "no state shall. . . pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility." U.S. Const. art. 1, § 10. Similarly, the Contracts Clause of the Louisiana Constitution states that "no bill of attainder, ex post facto law, or law impairing the obligation of contracts shall be enacted." La. Const. art. 1, § 23. Courts have concluded that the Contracts Clauses of the Louisiana and Federal Constitutions are "virtually identical" and "substantially similar" and the Louisiana Supreme Court has adopted the analysis enunciated by the United

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18. Doc. 48 (Memorandum in Support of Defendant's Motion to Dismiss, or in the Alternative, For Summary Judgment, p. 12).

States Supreme Court.[19] *See, e.g., Smith v. Bd. of Trustees of Louisiana State Employee's Retirement Sys.*, 851 So. 2d 1100, 1108-09 (La. 2003). Therefore, although two Contract Clauses are at issue, this court need only engage in one Contract Clause analysis.

As a preliminary matter, the defendant argues that Directive 175 does not change the law; however, even if Directive 175 did change the law, the defendant argues that any change does not affect existing contracts, only future contracts. In support of its position, the defendant cites *Guidroz v. Lewis*, 626 So. 2d 736 (La. App. 5 Cir. 1993).

In *Guidroz*, the court examined the retroactive or prospective application of administrative directives by the Commissioner of Insurance. The court noted it found no authority that would mandate that the Insurance Commissioner's determination be applied retroactively.

Although the court recognized that Louisiana's rule on the retroactivity of laws referred to "*laws* rather than administrative directives," the court still found the rules of construction to be instructive. *Id.* at 739 (emphasis in original). Louisiana Civil Code article 6 states that, "in the absence of contrary legislative expression, substantive laws apply prospectively only. Procedural

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19. The analysis adopted by the United States Supreme Court is explained in *Energy Reserves Group, Inc. v. The Kansas Power & Light Co.*, 459 U.S. 400 (1983). The Court ruled that the "threshold inquiry is 'whether the state law has, in fact, operated as a substantial impairment of a contractual relationship.'"

and interpretative laws apply both prospectively and retroactively, unless there is a legislative expression to the contrary."[20]

The *Guidroz* court concluded that substantive laws apply prospectively and even interpretative legislation "cannot operate retroactively to disturb vested rights." *Id.* at 739. *See also Am. Fin. Corp. of Coushatta v. Small*, 250 So. 2d 768 (La. App. 2 Cir. 1971).[21] Thus, whether the plaintiff argues that Directive 175 was a substantive change in the law, or an interpretive change, the Directive need not be given a retroactive effect. If Directive 175 has no retroactive effect, the Contract Clause is not implicated. Again, the plaintiff has failed to cite any authority or explain how Directive 175 violates the Contracts Clause of the United States Constitution or the Louisiana Constitution.

IV. Legal Authority to Support the Enforcement of Directive 175

The plaintiff attempts to challenge the substance of Directive 175 and asserts that there is a lack of legal authority to support the make whole doctrine or

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20. In evaluating the retroactively of laws, the Louisiana Civil Code recognizes three types of laws: substantive, procedural, and interpretative.

21. The court explained that even remedial statutes that have a retroactive effect "should not be construed to operate retroactively where vested rights are impaired" because such an interpretation would run afoul of the Federal and State Constitutions. *Small*, 250 So. 2d at 770.

attorney fee provisions contained in Directive 175.[22] However, in a prior ruling, this court decided that matters addressing whether Directive 175 contravened Louisiana law would not be decided by this court.[23]

Specifically, this court ruled that "insofar as Benefit Recovery seeks declaratory or injunctive relief that Directive 175 is contrary to Louisiana law, Benefit Recovery's claims are barred by the Eleventh Amendment."[24] Accordingly, this court expresses no opinion as to whether the substance of Directive 175's provisions has adequate support in Louisiana law.

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22. *See* Doc. 58 (Plaintiff's Memorandum to Defendant's Motion to Dismiss or, Alternatively, Motion for Summary Judgment, p. 6). *See also* Doc. 52 (Plaintiff's Memorandum in Support of Motion for Summary Judgment, p.2) (stating that "rather than attempt to impose the provisions of Directive 175 through the legislative process, Defendant unilaterally and unconstitutionally imposed Directive 175 on insurers in excess of its statutory and constitutional authority.")

23. Doc. 17 (Ruling on Motion to Dismiss).

24. Doc. 17, p. 9.

Appendix C

CONCLUSION

For the reasons stated herein, the defendant's Motion to Dismiss based upon a lack of standing is DENIED. The defendant's Motion for Summary Judgment based upon ERISA preemption and the Contract Clause is GRANTED. Therefore, the plaintiff's Motion for Summary Judgment is DENIED.

Baton Rouge, Louisiana, December 5th, 2006.

s/ James J. Brady
JAMES J. BRADY
UNITED STATES DISTRICT JUDGE

APPENDIX D — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT DENYING PETITION FOR REHEARING AND REHEARING EN BANC FILED APRIL 8, 2008

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 07-30414

BENEFIT RECOVERY INC

Plaintiff - Appellant

v.

JAMES J DONELON, in His Official Capacity as Commissioner of Insurance for the State of Louisiana

Defendant - Appellee

Appeal from the United States District Court for the Middle District of Louisiana, Baton Rouge

ON PETITION FOR REHEARING AND REHEARING EN BANC

(Opinion 03/11/08, 5 Cir., ____, ____ F.3d ____)

Before REAVLEY, SMITH, and DENNIS, Circuit Judges.

Appendix D

PER CURIAM:

The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (Fed. R. App. P. and 5th Cir. R. 35) the Petition for Rehearing En Banc is also DENIED.

ENTERED FOR THE COURT:

s/ Jerry Smith
United States Circuit Judge

101

No. 08-45

FILED

AUG 2 1 2008

OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The

Supreme Court of the United States

BENEFIT RECOVERY, INC.,

Petitioner,

v.

JAMES J. DONELON, in his Official Capacity as Commissioner of Insurance for the State of Louisiana,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

I. Whether Directive 175, which instructs Louisiana insurers on the mandatory contents of their insurance policies, is a "saved" insurance regulation, *i.e.*, one that alters the scope of permissible bargains between insurers and insureds, when it confers an economic benefit on insureds and could affect the cost of health insurance?

II. Whether the Petitioner preserved for appeal the separate argument that Directive 175 duplicates or supplements ERISA's civil enforcement provision, which argument it failed to raise in the district court?

III. Whether the Fifth Circuit correctly held that the Petitioner could not raise a new argument – that Directive 175 was improperly issued as a matter of *state law* – after the entry of judgment?

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STATEMENT OF THE CASE

The Petitioner, Benefit Recovery, Inc. ("Benefit Recovery"), is a Tennessee corporation. Its business includes, among other things, contracting with health insurers to identify medical expenses potentially subject to the subrogation or reimbursement provisions of insurance policies.[1] Benefit Recovery is not licensed as an insurer in Louisiana, and its activities are not regulated by the Louisiana Commissioner of Insurance (the "Commissioner").

In January 2004, Benefit Recovery contracted with Ochsner Health Plan of Louisiana ("OHP"), a Louisiana corporation. OHP was an HMO and insurer administering group health plans. In the contract, Benefit Recovery agreed to seek to enforce OHP's rights of subrogation or recovery arising out of claims for health-care benefits by insured persons. In return for its services, Benefit Recovery would receive a percentage of the recovery on any such claim.

The record does not reflect whether, and if so when, the Benefit Recovery/OHP contract ceased. Nevertheless, OHP was acquired by Humana Health Benefit Plans of Louisiana, Inc. ("Humana") in 2004.

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[1] As explained below, the parties entered into a written "Joint Stipulations and Designation of Exhibits" as part of their agreement to resolve this matter through cross-motions for summary judgment without a trial on the merits. The statements contained in this section are taken from those stipulations and exhibits.

The record does not reflect whether Benefit Recovery has provided any services to Humana.

In the context of Louisiana insurance regulation, a "directive" is a notice, published by the Commissioner, that communicates the law and policy of Louisiana and instructs insurers of the need to comply with the directive when drafting policies and related documents. In January 2003, the Commissioner promulgated Directive 175 (the "Directive"). The Directive, which was specifically brought to the attention of "all insurers and rate service organizations licensed or doing business in Louisiana," addresses subrogation provisions in insurance policies. Insurance policies should comport with the "make-whole" rule; policy language should clearly convey to insureds that "any right of recovery from third parties on the part of the insurer, whether by subrogation or reimbursement, is subordinate to the insured's right to be fully compensated for his damages. . . ." The Directive further notifies insurers of their obligation to share in the insured's legal expenses in the subrogation context. The Directive addresses the review process for insurance-policy forms and, in order to reduce the need for corrective action, proposes draft language for insurers to consider using.

Directive 175 applies only to insurance policies. It does not apply to self-funded benefit plans under ERISA, or to entities acting as "pure administrators" of such plans. As to insurers, however, the Commissioner has refused to approve the terms of insurance

policies, including policies issued to employer health plans, that did not comply with Directive 175.

OHP's insurance policies in 2001-02 and 2003-04 contained language inconsistent with Directive 175. The Commissioner required OHP to modify the subrogation terms to comply with the Directive. The record does not contain any policy forms used by Humana after its acquisition of OHP.

PROCEDURAL BACKGROUND

A. The parties agreed to have this matter decided on cross-motions without a trial.

Benefit Recovery sued the Commissioner in the Middle District of Louisiana in August 2003.[2] OHP was not a party to the suit, nor was any other Louisiana insurer. Benefit Recovery alleged that it has provided and will provide subrogation services to Louisiana health plans. Challenging Directive 175, Benefit Recovery alleged that enforcement of the Directive "will work irreparable harm on the health benefits providers represented by Plaintiff."[3] Benefit Recovery also alleged that enforcement of the Directive would

[2] In 2003, J. Robert Wooley was the Louisiana Commissioner of Insurance. He was succeeded in 2006 by James J. Donelon.

[3] Original Complaint for Declaratory and Injunctive Relief at ¶ XVIII.

harm insureds by increasing the cost of insurance coverage:

> Continued enforcement of Directive No. 175 will further harm all members of the plans represented by Plaintiff. Health benefits plans like those represented by Plaintiff calculate the premiums charged to members based in part on the amount of money they are likely to receive in subrogation from third-parties primarily responsible for payment of expenses incurred in treating injuries sustained by members through the negligence of the third-party. To the extent that subrogation is eliminated by the application of the Make Whole Doctrine demanded by Directive No. 175, or is curtailed by requiring extensive reimbursement of attorneys in subrogation and reimbursement actions brought by health benefits plans, the cost of health insurance in this state will rise significantly.[4]

Benefit Recovery also alleged that Directive 175 was promulgated without notice and comment; attempted to incorporate doctrines into health-benefit plans in a manner inconsistent with the separation of powers doctrine; and lacked a compelling, substantial, or rational basis. It further alleged that the Directive lacked a jurisprudential basis, violated the Contracts Clause of the Louisiana and United States

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[4] *Id.* at ¶ XIX.

Constitutions, and was completely preempted by ERISA.

The Commissioner initially moved to dismiss Benefit Recovery's complaint on three grounds.

First, the Commissioner argued that Benefit Recovery lacked Article III standing because it has not suffered an injury in fact. The district court disagreed, citing *Lujan v. Defenders of Wildlife*[5] and Benefit Recovery's potential loss of revenue under its contract with OHP.

Second, the Commissioner argued that the court lacked subject-matter jurisdiction because Benefit Recovery was not within the class of persons vested with an ERISA cause of action under 29 U.S.C. § 1132. The district court again disagreed, citing Fifth Circuit authority that a federal court has subject-matter jurisdiction over a suit alleging ERISA pre-emption even though the plaintiff may not have a private right of action under that statute.

And finally, the Commissioner invoked Eleventh Amendment immunity. The district court agreed in part. It recognized that a federal court cannot instruct state officials on how to conform their conduct to state law. Accordingly, it found that the Eleventh Amendment barred Benefit Recovery's claim for declaratory and injunctive relief to the extent based on Louisiana law. Nevertheless, the court stated that

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[5] 504 U.S. 555 (1992).

the Commissioner could be sued, in his official capacity, for prospective injunctive relief to end an alleged violation of federal law. Accordingly, the court held that the Eleventh Amendment did not preclude Benefit Recovery's request for injunctive relief against the enforcement of Directive 175 on the basis of federal law.

The parties later presented their substantive arguments to the court through cross-motions for summary judgment. Contrary to Benefit Recovery's assertions, the district court did not simply dismiss Benefit Recovery's case on a routine Rule 56 motion that addressed less than all of the issues. Instead, and because the few facts that were relevant were not in dispute, the parties *jointly* proposed that the district court decide the case on cross-motions for summary judgment *without a trial*. To that end, Benefit Recovery, along with the Commissioner, represented the following to the district court:

> The parties to this action share a common belief that this action presents only a few discrete issues of law that could be resolved short of adducing testimony at trial. The parties have agreed to reach stipulations of fact and to present the legal issues inherent in this case to the court in either trial memoranda or cross-motion format to be submitted on a schedule to be established by this court.[6]

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[6] Joint Motion to Establish Submission and Briefing Deadlines at ¶ 3.

Benefit Recovery understood that it was incumbent upon it to raise whatever arguments it wished in its motion. It further understood that the motion would take the place of a trial and dispose of the entire case.

B. The district court ruled in favor of the Commissioner after addressing all arguments raised by Benefit Recovery.

The district court agreed with the parties' proposal and signed an order setting a schedule for the filing of dispositive motions or trial memoranda. To facilitate that process, they drafted and filed a set of joint stipulations and submitted a handful of agreed-upon documents.

The Commissioner filed his motion first. He asked the court to dismiss Benefit Recovery's complaint on grounds of prudential standing and, in the alternative, requested summary judgment. As to prudential (not Article III) standing, the Commissioner argued that Directive 175 applies only to Louisiana insurers, not contractors (like Benefit Recovery) that render services to insurers. Since no obstacle exists to a challenge to the Directive by a Louisiana insurer, Benefit Recovery lacked prudential standing. In support of its alternative motion for summary judgment, the Commissioner argued that ERISA did not preempt Directive 175, which is a "saved" insurance regulation that is not applied to self-funded ERISA plans. And finally, the Commissioner

demonstrated that Benefit Recovery's Contracts Clause claim lacked merit.

Benefit Recovery likewise moved for summary judgment. It asserted that the Directive is a "State law" preempted by ERISA. It also argued that the Directive is *not* a "law of any State" for purposes of the saving clause, and further, does not substantially affect the risk-pooling arrangement between insurers and insureds.

The district court granted the Commissioner's motion for summary judgment and issued a 24-page opinion outlining its legal analysis. The court decided that Benefit Recovery had prudential standing to challenge the enforcement of Directive 175. It nevertheless found that the Directive is a "saved" state law, as defined by ERISA, that is specifically directed toward the insurance industry. The Directive substantially affects the risk-pooling arrangement between insurers and insureds. Citing *Kentucky Ass'n of Health Plans, Inc. v. Miller*, the court explained that the Directive "alters the scope of permissible bargains between insurers and insureds."[7] And finally, the court rejected Benefit Recovery's Contracts Clause argument, a claim that the plaintiff did not defend in its motion papers.

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[7] 538 U.S. 329 (2003).

C. After having its case dismissed, Benefit Recovery attempted to raise new arguments through a motion to alter to amend the judgment; the district court denied the motion.

Shortly after the ruling, Benefit Recovery moved the district court to alter or amend its judgment. First, Benefit Recovery raised a new argument and asked the district court to decide whether Directive 175 was valid on state-law grounds – wholly apart from the ERISA-preemption issue. And second, it asked for another opportunity to submit evidence on the saving-clause analysis. The Commissioner opposed the motion.

The district court refused to entertain Benefit Recovery's state-law argument, which was "a new legal argument that cannot be urged under Rule 59(e)." In its motion for summary judgment, the court continued, "Benefit Recovery has relied on a theory of ERISA preemption. Now that this court has ruled against it, the plaintiff attempts to advance a different legal theory."[8]

The court also rejected the plaintiff's assertion that the court somehow refused to let it present evidence bearing on the saving-clause factors. Benefit Recovery's summary judgment memorandum cited *Miller* and argued that Directive 175 did not satisfy its criteria. The court rejected those arguments on the

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[8] Ruling on Plaintiff's Motion to Alter or Amend Judgment, Appendix B to Petition for Writ of Certiorari or Review at 14a.

merits. "Now presented with a ruling against it, the plaintiff argues that it was not permitted to present evidence regarding the *Miller* factors."[9] The court squarely rejected the plaintiff's premise. "It must be remembered that this matter was before the court on Cross-Motions for Summary Judgment. It was the obligation of the parties to present competent evidence and to direct the court to evidence in the record supporting their respective positions."[10] The plaintiff's failure to offer "additional evidence to support its position is insufficient to warrant a Rule 59(e) motion."[11]

D. The Fifth Circuit affirmed the district court.

Benefit Recovery appealed these rulings, and the Fifth Circuit affirmed.[12] The Fifth Circuit began its review by recognizing that "[t]he parties proposed the case be decided on cross-motions for summary judgment and filed joint stipulations of fact."[13] In terms of legal analysis, the Fifth Circuit's opinion is divided into three sections. First, the court addressed Benefit Recovery's new argument on appeal that "ERISA's complete preemption provision, 29 U.S.C. § 1132(a)

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[9] *Id.* at 16a.

[10] *Id.* at 16a-17a.

[11] *Id.* at 17a.

[12] 521 F.3d 326.

[13] *Id.* at 328.

("Section 502") preempts Directive 175."[14] The court did not reach the merits of that issue, finding that the argument had been waived:

> Benefit, however, has not preserved that issue for appeal. . . . Benefit's motion for summary judgment makes explicit that the issue is whether Section 514 preempts Directive 175. The question whether Section 502 preempts the Directive is therefore presented for the first time on appeal, so we do not reach the merits of Benefit's claim. Realizing this hurdle, Benefit seeks to invoke our appellate power through a backdoor: In its reply brief, it urges that parties do not expect cross-motions for summary judgment to end their case. Regardless of the legal merits of such an expectation, Benefit has waived our review of the dismissal of the case, because arguments cannot be raised for the first time in a reply brief.[15]

Second, the court made a similar finding with respect to Benefit Recovery's argument that "Directive 175 is invalid as a matter of federal law because it is an improperly issued state regulation purporting to supply a rule of decision for ERISA plans."[16] The Fifth Circuit determined that Benefit Recovery

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[14] *Id.* at 329.

[15] *Id.* (citing *Yohey v. Collins*, 985 F.2d 222, 225 (5th Cir. 1993)).

[16] *Id.*

waived that argument, as well, by failing to include it in its motion for summary judgment:

> We do not reach the merits of the argument, because Benefit raised it only after entry of judgment. Benefit made the argument for the first time in its unsuccessful rule 59(e) motion. . . . Throughout its submissions to the district court, Benefit relied on a theory of ERISA preemption. When the district court found that argument unavailing, Benefit presented the new argument. The district court did not abuse its discretion in refusing to change its judgment in response to Benefit's motion.[17]

And third, the Fifth Circuit addressed the only merits-based issue squarely presented by Benefit Recovery's appeal, namely, whether "ERISA's conflict preemption section, 29 U.S.C. § 1144(a) ("Section 514"), preempts Directive 174."[18] In concluding that the Directive regulates insurance and is thus "saved" from preemption, the Fifth Circuit rejected the artificial distinction between "State laws" and "laws of any State" created by Benefit Recovery:

> Given the similar breadth of the clauses, if statutes and state supreme court decisions are "State laws," it follows that rules, regulations, and anything else having the effect of law are as well. Nor is there a problem with

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[17] *Id.*

[18] *Id.* at 330.

> the exception's swallowing the rule. State laws need only "relate to" insurance to fall within ERISA preemptive scope; only those laws that regulate insurance are saved. We therefore decline to extend the test set forth in *Miller* by effectively adding a new requirement – distinguishing "State laws" from "laws of any State."[19]

Completing the analysis, the Fifth Circuit confirmed the district court's finding that a directive that instructs insurers as to the circumstances under which they may seek reimbursement from their insureds certainly affects "risk pooling" and is not subject to ERISA preemption.[20]

Benefit Recovery's Petition to this Court followed.

REASONS FOR DENYING THE PETITION

Benefit Recovery waived two-thirds of the issues raised in the Petition. Accordingly, and as the Fifth Circuit recognized, this matter presents only one substantive question, *i.e.*, whether Directive 175 is preempted under section 514 of ERISA. Because the Directive clearly is saved from preemption, Benefit Recovery has not demonstrated any compelling reason for the Court to grant its Petition.

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[19] *Id.* at 331.

[20] *Id.*

I. THE FIFTH CIRCUIT PROPERLY HELD THAT BENEFIT RECOVERY FAILED TO PRESERVE FOR APPEAL THE ARGUMENT THAT DIRECTIVE 175 IS PREEMPTED BY SECTION 502 OF ERISA.

A state statute or regulation may conflict with ERISA in one of two ways.[21] First, the law might be preempted as one that "relate[s] to" employee benefit plans.[22] And second, the law might conflict with ERISA's exclusive enforcement scheme. Benefit Recovery's initial argument relies upon an alleged conflict between Directive 175 and ERISA's enforcement provision, section 502(a).[23] Relying heavily on *Aetna Health, Inc. v. Davila*,[24] Benefit Recovery argued for the first time on appeal that Directive 175 impermissibly supplemented available remedies under ERISA. The argument lacks merit, but as a threshold matter, and as the Fifth Circuit recognized, Benefit Recovery did not preserve this issue for appeal.

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[21] *Louisiana Health Service & Indem. Co. v. Rapides Health Care System*, 461 F.3d 529, 533 (5th Cir. 2006), *cert. denied*, 127 S.Ct. 1831 (2007).

[22] *Id.*

[23] 29 U.S.C. § 1132(a).

[24] 542 U.S. 200 (2004).

"A party must press, not merely intimate, an argument, in order to preserve it for appeal."[25] "The raising party must present the issue so that it places the opposing party and the [district] court on notice that a new issue is being raised."[26] "If an argument is not raised to such a degree that the district court has an opportunity to rule on it, [a court] will not address it on appeal.[27] Under this analysis, Benefit Recovery has clearly waived its *Davila*-based preemption argument. As noted, the district court resolved this case – at the parties' request – on cross-motions for summary judgment. At no time in its moving or opposing pleadings did Benefit Recovery ever contend that Directive 175 impermissibly duplicates or supplements ERISA's civil-enforcement scheme. Instead, it argued only that the Directive "relate[s] to" ERISA plans and does not fall within ERISA's saving clause. As noted in *Louisiana Health Service Indemnity Co. v. Rapides Health Care System*,[28] challenges to state laws based on (1) ERISA's civil-enforcement mechanism and (2) the "relate to" analysis are "*separate preemption arguments.*"[29] Because Benefit Recovery may not raise a new argument on appeal, the Fifth

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[25] *Kelly v. Foti*, 77 F.3d 819, 823 (5th Cir. 1996); *see also Keelan v. Majesco Software, Inc.*, 407 F.3d 332, 340 (5th Cir. 2005).

[26] *Kelly*, 77 F.3d at 823 (quoting *Portis v. First National Bank*, 34 F.3d 325, 331 (5th Cir. 1994)).

[27] *FDIC v. Mijalis*, 15 F.3d 1314, 1327 (5th Cir. 1994).

[28] 461 F.3d 529 (5th Cir. 2006).

[29] *Id.* at 533 (emphasis added).

Circuit was right to not consider this new, separate argument based on *Davila*.

Apart from the procedural bar, *Davila* simply has no application to this case. *Davila* confirmed that a "state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted."[30] The Texas statute in question created a cause of action in favor of any person injured by a plan administrator's negligent handling of coverage decisions. A successful plaintiff could recover damages. This Court held that the statute was preempted because ERISA already provided a cause of action for a plan participant to recover wrongfully denied benefits.[31] Because the alleged injuries covered by the Texas statute and ERISA (section 502(a)(1)(B)) were duplicative, the Texas statute was unenforceable.

In *Louisiana Health Service & Indemnity Co.*, the Fifth Circuit addressed a preemption attack on Louisiana's Assignment Statute,[32] which required insurance companies to honor all assignments of claims made by patients in favor of hospitals. Like Benefit Recovery, the plaintiff relied upon *Davila* and

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[30] *Davila*, 542 U.S. at 208 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985) (internal quotation marks and citation omitted)).

[31] *Id.* at 214.

[32] La. Rev. Stat. Ann. § 40:2010.

conflict preemption. In rejecting that argument, the Court first noted ERISA's silence on the assignability of employee welfare benefits: "it neither prohibits assignments nor mandates recognition of assignments."[33] In contrast, the court noted, the Texas statute at issue in *Davila* was preempted, in large part, "because of the specific enforcement provisions provided by Congress."[34] The Court then emphasized that the Assignment Statute "does not create an additional means to enforce payment of benefits under an ERISA plan."[35] Once again, this contrasted with *Davila*, which created a new duty on the part of HMOs and imposed liability for any damages proximately caused by the breach of that duty.[36]

As is the case with respect to the assignability of welfare benefits, ERISA is silent on the matter of subrogation.[37] Moreover, Directive 175 does not create a new cause of action or "an additional means" of recovering benefits due from a plan. As explained later in more detail, the Directive, in enforcing the make-whole rule, assures full and comprehensive insurance coverage for Louisiana insureds. In the

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[33] *Louisiana Health Service & Indem. Co.*, 461 F.3d at 535-36.

[34] *Id.* at 535.

[35] *Id.*

[36] *Id.* (citing Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a) (Vernon 2004)).

[37] *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 140 (8th Cir. 1997).

absence of the make-whole rule, as Judge Richard Posner has cogently explained, an insured could be required to "pay back the policy benefits with money he has received for another loss caused by the injury that gave rise to the policy claim, as a result of which the insured would have an uncompensated injury."[38] In simple terms, the make-whole rule embodied in Directive 175 regulates the content of insurance policies and protects insureds against uncompensated losses. In the absence of the rule, health insurance is sometimes only a fleeting benefit. Addressing that circumstance is a matter entrusted to Louisiana's insurance regulators. This Court has never held that state laws regulating the content and required benefits of insurance policies conflict with ERISA's enforcement mechanism, whether the law in question was the requirement for equal mental-health coverage in *Metropolitan Life*,[39] the notice-prejudice rule at issue in *UNUM*,[40] or the any willing provider ("AWP") law in *Miller*.[41]

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[38] *Cutting v. Jerome Foods, Inc.*, 993 F.3d 1293, 1298 (7th Cir. 1993).

[39] *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

[40] *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999).

[41] *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).

II. ASSUMING THAT DIRECTIVE 175 RELATES TO EMPLOYEE BENEFIT PLANS, THE FIFTH CIRCUIT CORRECTLY HELD THAT ERISA DOES NOT PREEMPT IT BECAUSE IT REPRESENTS THE STATE REGULATION OF INSURANCE.

In *Miller,* this Court carefully examined ERISA's saving clause in the context of insurance regulation. *Miller* held that Kentucky's AWP law was a saved insurance regulation. The Court broke from an earlier analysis for determining whether a state law regulates insurance and articulated a new test, which asks:

(1) Is the state law specifically directed towards the insurance industry?

(2) Does the state law substantially affect the risk-pooling arrangement between the insurer and the insured?

As discussed below, with respect to Directive 175, the answer is "yes" to both questions.

A. Directive 175 addresses the conduct of Louisiana insurers and regulates the content of policy forms.

The Louisiana Commissioner of Insurance has full authority to regulate insurers and insurance policies.[42] ERISA does not diminish that authority. As

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[42] LA. CONST. art. IV, § 11; La. Rev. Stat. Ann. § 22:2(A)(1).

this Court explained in *FMC Corp. v. Holliday*,[43] there is "a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not. . . ."[44] Benefit Recovery predictably complains about diminished national uniformity, but that is the price of Congress' intention to respect the states' traditional role in the regulation of insurance. As explained in *Metropolitan Life* and again in *UNUM*, "[s]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation."[45]

Directive 175 applies exclusively to Louisiana insurers. Those insurers, as a matter of state law, must submit their policy forms to the Commissioner of Insurance for approval.[46] The Directive notifies those insurers about the mandatory contents of their insurance policies, and it proposes language for insurers to consider using in their policy forms. The Directive does not apply to any entity other than a Louisiana insurance company. Thus, the Directive is decidedly *not* a law of general application. Indeed, the Commissioner of Insurance lacks authority to issue directives affecting any industry other than the insurance industry. In its complaint, Benefit Recovery

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[43] 498 U.S. 52, 61 (1990).

[44] *Id.*

[45] *Metropolitan Life*, 471 U.S. at 747; *UNUM*, 526 U.S. at 376 n. 6.

[46] *See* La. Rev. Stat. Ann. § 22:621(3).

implicitly acknowledged the point. It sought an injunction prohibiting the enforcement of the Directive "*against any health benefits provider in the State of Louisiana.*"[47]

Benefit Recovery also contends that Directive 175 is not a "law." As the district court noted, this resulted in an internal contradiction in its argument:

> If this court accepts the premise that Directive 175 is not a "state law" and not subject to ERISA's saving[ ] clause, the plaintiff may have won that battle, but it will have lost the war. Arguing that Directive 175 is not a "state law" is a dubious argument that places the plaintiff on unsteady footing and causes a more problematic issue to come to light. The United States Code provides that ERISA's

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[47] Benefit Recovery suggests that the saving clause does not apply because Directive 175 "is directed only at *health* insurers, not insurers as a whole. . . ." Petition at 25-26 (emphasis in original). Benefit Recovery cites no support for its suggestion that only state laws that address insurers "as a whole" fall within the saving clause, and we are aware of none. In fact, the suggestion is directly contrary to *Miller*; *Miller* addressed a law providing that "[a] *health insurer* shall not discriminate against any provider who is located within the geographic coverage area of the *health benefit plan* and who is willing to meet the terms and conditions for participation established by the *health insurer*, including the Kentucky State Medicaid Program and Medicaid partnerships." *Miller*, 538 U.S. at 331-32 (emphasis added). Notwithstanding the narrow focus of Kentucky's AWP law, the Court held that the law fell within the saving clause because it was specifically directed toward entities engaged in insurance. *Id.* at 334-35.

> preemptive power applies to "state laws." The term "state law" is defined only once in the ERISA context. *Accordingly, if Directive 175 is not a "state law" for the purpose of ERISA's saving clause; it is also not a "state law" that is subject to ERISA preemption.* This would make Directive 175 immune from ERISA's reach and there would be no need to even conduct a saving clause analysis.[48]

The district court was, of course, correct. ERISA defines the term "State law" to include "all laws, decisions, rules, regulations, or other State action having the effect of law of any State."[49] Benefit Recovery has acknowledged that, if insurers fail to comply with the instructions in the Directive, they "will be subject to sanctions including but not limited to the imposition of such fines as are authorized by law." Whether treated as a "quasi-regulation" – a term used by Judge Sarah Vance of the Eastern District of Louisiana[50] – a written communication or order; or

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[48] Ruling on Cross Motions for Summary Judgment, Appendix C to Petition for Writ of Certiorari or Review at 30a (emphasis added).

[49] 29 U.S.C. § 1144(c)(1).

[50] *Gauthreaux v. USAA Cas. Ins. Co.*, 2001 WL 65573 (E.D. La. Jan. 25, 2001), at *2 (taking judicial notice of Directive No. 18 as a matter of public record and as a governing quasi-regulation). *See also generally* La. Rev. Stat. Ann. § 22:1316(A) ("A person subject to the regulatory authority of this department who fails to comply with any directive issued by the commissioner in connection with a consumer complaint shall be fined an amount not to exceed two hundred and fifty dollars for each occurrence").

some other type of official instrument, it is clear that, at a minimum, a directive is state action that instructs insurers on permitted practices and cautions them about the consequences of non-compliance. Nothing more is needed.

Benefit Recovery argues at length that the term "State law" as used in ERISA's preemption clause (section 514(a)) is different from the phrase "law of any State" for purposes of the saving clause (section 514(b)(2)(A)). Benefit Recovery sees "a fundamental, albeit subtle, distinction" between those references.[51] It argues that what constitutes state law for purposes of the saving clause is far narrower and must reflect actual legislation, and not merely "a regulation issued by a state insurance commissioner. . . ."[52] Benefit Recovery cites no jurisprudential support for its reading of the statute, and its argument conflicts squarely with *UNUM* in two important ways.

First, whereas Benefit Recovery contends that the saving clause applies only to "actual legislation," *UNUM* applied the saving clause to a jurisprudential rule.[53] *UNUM* is fully consistent with the broad language of ERISA, which classifies "decisions, rules, regulations, or other state action having the effect of law" as a "state law."[54]

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[51] Petition at 21.

[52] *Id.*

[53] *UNUM*, 526 U.S. at 366-67.

[54] *Id.* at 367, n. 1.

And second, no basis exists to interpret references to state law in the same statute in dramatically different ways. In a unanimous opinion, the *UNUM* Court expressly noted that ERISA's two references to state law were equally broad:

> The preemption clause [of ERISA], § 514(a), 29 U.S.C. § 1144(a), broadly states that ERISA provisions *"shall supercede . . . State laws"* to the extent that those laws "relate to any employee benefit plan." The saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), *phrased with similar breadth, exempts from preemption "any law of any State which regulates insurance."*[55]

Benefit Recovery *admits* that Directive 175 is a "State law" for purposes of section 514(a).[56] It is, therefore, estopped to dispute that the same Directive is also a state law for purposes of section 514(b)(2)(A).[57] As *UNUM* confirms, a state law is a state law – period.

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[55] *Id.* at 363 (emphasis added).

[56] Benefit Recovery concedes that Directive 175 is a "State law" as defined in ERISA. *See* Petition at 19, citing 29 U.S.C. § 1144(c)(1). "Accordingly, because Directive 175 has the effect of law, there is no need to engage in a 'metaphysical inquiry into the nature of law'" (in the words of the Fifth Circuit) in order to find that Directive 175 falls within the scope of 1144(a)." *Id.*

[57] *Hall v. GE Plastic Pacific PTE Ltd.*, 327 F.3d 391, 397 (5th Cir. 2003) ("'[A] party cannot advance one argument and then, for convenience or gamesmanship after that argument has served its purpose, advance a different and inconsistent argument'"

(Continued on following page)

B. Directive 175 affects the risk-pooling arrangement between insurers and insureds; it alters the scope of permissible bargains in the insurance arena.

The second part of the *Miller* test asks whether the state law in question substantially affects the risk-pooling arrangement between insurers and insureds.[58] A law that "alters the scope of permissible bargains" between insurers and insureds – like Kentucky's AWP law – satisfies this test.[59] More generally, laws and regulations that affect an insurer's costs and, thus, the premiums that the insurer will charge, also affect the risk-pooling arrangement.[60]

Benefit Recovery's complaint virtually concedes the point. It tacitly acknowledges that protecting insureds from reimbursement actions in cases in which the insureds are not made whole confers an additional benefit on insureds and imposes a corresponding cost on insurers. The result, Benefit Recovery predicts, could be increased premiums. Assuming

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(quoting *Hotard v. State Farm Fire & Cas. Co.*, 286 F.3d 814, 818 (5th Cir. 2002))).

[58] *Miller*, 538 U.S. at 338. Prior to *Miller*, under the McCarran-Ferguson analysis, the test asked whether the state law *actually spread the risk*. Now, the test asks only whether the law *affects* the risk-pooling arrangement. *Id.* at 339.

[59] *Id.* at 338-39.

[60] *See Louisiana Health Service & Indem. Co. v. Rapides Health Care System*, 461 F.3d 529 (5th Cir. 2006) (Owen, J., concurring).

that is true, an increased premium for an enhanced benefit ought to surprise no one. As Congress and the courts have recognized, this is a policy decision for Louisiana's insurance regulators to make.[61]

FMC Corp. v. Holliday[62] provides important guidance on the viability of Directive 175. *FMC* addressed a Pennsylvania anti-subrogation law, which an insurer challenged on ERISA-preemption grounds. The context was a reimbursement action filed by a health plan; the health plan was self-funded and thus wholly exempt from state regulation. The plan sought to recoup benefits it paid to an accident victim, but the victim objected, citing a state law that precluded subrogation from a claimant's tort recovery under certain circumstances.[63] This Court held that ERISA preempted the state law – *but only in the context of a self-funded plan*. It recognized that the law would have been fully enforceable in the context of an *insured plan*, because an insured plan remains subject to indirect state regulation:

> *There is no dispute that the Pennsylvania law falls within ERISA's insurance-saving clause*, which provides, "except as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve

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[61] *E.g., Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (state law that mandated employer-provided coverage for mental health fell within saving clause).

[62] 498 U.S. 52 (1990).

[63] *Id.* at 55 (citing 75 Pa. Cons. Stat. § 1720 (1987)).

> any person from any law of any State which regulates insurance. . . ." *[The Pennsylvania law] directly controls the terms of insurance contracts by invalidating any subrogation provisions they contain. . . .* It does not merely have an impact on the insurance industry; it is aimed at it. . . . *This returns the matter of subrogation to state law.*[64]

This passage from *FMC* applies squarely to our case. Directive 175 is an insurance-specific bulletin advising Louisiana insurers that the Commissioner of Insurance will reject insurance-policy forms that do not comply with the make-whole rule. The parties have stipulated that the Commissioner does not enforce Directive 175 against self-funded plans qualified under ERISA. Under *FMC*, then, the Directive is a "saved" insurance regulation.[65]

Without evidence, Benefit Recovery insists that laws addressing subrogation bear no relation to the risk insured against and thus, by definition, do not

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[64] *Id.* at 60-61 (citations omitted; emphasis added).

[65] The district court properly rejected Benefit Recovery's reliance on *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989). The district court recognized that *Baxter*, a pre-*Miller* case from the Eighth Circuit, held only that an anti-subrogation law does not *transfer* the risk from a policy-holder to his or her insurer. But under *Miller*, the law need not actually transfer the risk so long as it substantially affects the risk-pooling arrangement. That effect is beyond good-faith debate. Moreover, several circuits have rejected the reasoning underlying *Baxter* and ruled that anti-subrogation laws meet the (now-superseded) McCarran-Ferguson test.

substantially affect the risk-pooling arrangement between insurers and insureds. Even under the pre-*Miller* analysis, Benefit Recovery is wrong as a matter of basic economics. Judge Posner of the Seventh Circuit reviewed the basic principles underlying the make-whole rule and recognized that differences in subrogation rules may increase or decrease available insurance coverage:

> [S]ubrogation clauses are a common feature of insurance policies. But the "make whole" issue is not about whether insurance subrogation is in general a good thing, as it doubtless is. A "make whole" rule does not enable the insured to gamble on double recovery, as he would be doing without subrogation. *The rule comes into play only if without it the operation of the subrogation clause would, by making the insured in effect pay back the policy benefits with money he has received for another loss caused by the injury that gave rise to the policy claim, leave him with an uncompensated injury.*
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> * * *
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> *If insurance contracts required the insured to assign any tort claim he might have to the insurer, the price of the insurance would be lower but effective coverage would also be lower.* The insured would recover only the policy limits, and not his full damages, even in the case in which a judgment had been secured against

the tortfeasor, and collected, for those damages.[66]

Judge Posner's observations are difficult to refute, and they expose the error of Benefit Recovery's argument. Directive 175, in calling upon Louisiana insurers to comply with the make-whole rule in their policies, effectively mandates *increased coverage*. It avoids the risk that injured insureds will not be fully compensated for their losses. The Directive thus "alters the scope of permissible bargains" between insurers and insureds and easily satisfies the standard articulated in *Miller*.

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[66] *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298 (7th Cir. 1993) (emphasis added). The Fifth Circuit has cited Judge Posner's opinion favorably, specifically for its observations about the economic effect of rejecting the make-whole rule in favor of absolute subrogation or reimbursement rights. *Sunbeam-Oster Co. v. Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees*, 102 F.3d 1368, 1376 n. 23 (5th Cir. 1996) (addressing a self-funded plan). The Eighth Circuit, as well, has recognized that the nature of the subrogation applicable under an insurance policy "affects the level of benefits conferred by the plan. . . ." *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 139-40 (8th Cir. 1997).

III. THE FIFTH CIRCUIT PROPERLY REFUSED TO CONSIDER BENEFIT RECOVERY'S POST-JUDGMENT ATTEMPT TO QUESTION THE VALIDITY OF DIRECTIVE 175 AS "SURROGATE FEDERAL LAW."

Benefit Recovery's final argument is that Directive 175, even if not preempted, is an invalid regulation. In order to get around Eleventh Amendment immunity, Benefit Recovery attempts to re-classify Directive 175 as *surrogate federal law*. The effort is unpersuasive.

Benefit Recovery failed to raise this argument in a timely manner in the district court.[67] As it acknowledged below, Benefit Recovery did not argue in its motion for summary judgment (or in opposition to the Commissioner's motion) that the district court should determine the validity of Directive 175 as surrogate federal law. Its argument in that regard came only after the entry of an adverse judgment, in the context of its Rule 59(e) motion. Benefit Recovery evidently assumed that, once the district court rejected its contention that ERISA should preempt Directive 175, it "should have left open the issue of whether Directive 175, as a matter of federal law, is valid."[68] The

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[67] *Kelly v. Foti*, 77 F.3d 819, 823 (5th Cir. 1996); *Portis v. First National Bank*, 34 F.3d 325, 331 (5th Cir. 1994).

[68] Reply Memorandum in Support of Plaintiff Benefit Recovery, Inc.'s Rule 59(e) Motion to Alter or Amend Judgment at 2.

Fifth Circuit upheld the district court's decision not to consider that untimely argument:

> Throughout its submissions to the district court, Benefit relied on a theory of ERISA preemption. When the district court found that argument unavailing, Benefit presented the new argument. The district court did not abuse its discretion in refusing to change its judgment in response to Benefit's motion.[69]

The Fifth Circuit correctly held that Benefit Recovery has not shown an abuse of discretion. In the event this Court chooses to consider Benefit Recovery's argument on the merits, however, it should reject that argument for two fundamental reasons.

First, Benefit Recovery's insistence that Directive 175 has been transformed into federal law is based upon a misreading of the jurisprudence – principally the *UNUM* case. As Benefit Recovery relates, *UNUM* stated that California's notice-prejudice rule supplied "the relevant rule of decision" in an ERISA action.[70] Benefit Recovery reasons that Directive 175, as well, supplies the relevant rule of decision here. From this, Benefit Recovery leaps to the conclusion that the interpretation and validity of the Directive are federal issues. The logic is flawed. Benefit Recovery has misread *UNUM's* reference to the notice-prejudice rule as providing the rule of decision. This Court was

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[69] 521 F.3d at 329.

[70] *UNUM*, 526 U.S. at 377.

addressing the insurer's contention that the state rule duplicated ERISA's civil enforcement provision.[71] In rejecting that argument, the Court explained that the state rule did not authorize an alternate route to collect welfare benefits. Only one route existed – the federal route – and California's insurance regulation fit within it:

> Ward [the insured] sued under § 502(a)(1)(B) "to recover benefits due . . . under the terms of his plan." The notice-prejudice rule supplied the relevant rule of decision for this § 502(a) suit. *The case therefore does not raise the question whether § 502(a) provides the sole launching ground for an ERISA enforcement action.*[72]

In a later passage, the Court again noted that the insured based his suit on § 502(a)(1)(B) for benefits due and "seeks only the application of *saved state insurance law as a relevant rule of decision in his § 502(a) action.*"[73] Nowhere in the opinion did the *UNUM* Court deem California's notice-prejudice rule to be a matter of federal law.

And second, the Eleventh Amendment divests the federal courts of jurisdiction to instruct state officials on how to conform their conduct to state law.

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[71] *Id.* at 376-77.

[72] *Id.* at 377 (emphasis added).

[73] *Id.* at 377, n. 8 (emphasis added).

In the seminal *Pennhurst* case,[74] this Court held that a federal suit against state officials on the basis of state law contravenes the Eleventh Amendment when the relief sought would have an impact directly on the state itself.[75] The Eleventh Amendment equally bars supplemental state-law claims, even if the requirements of 28 U.S.C. § 1367 are satisfied.[76] Accordingly, if Benefit Recovery had openly asked the district court to determine the validity of Directive 175 under state law, such as by deciding whether the Commissioner had the legal authority to promulgate the Directive, the Eleventh Amendment would have barred its request.

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[74] *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89, 106 (1984).

[75] *Id.* at 120.

[76] *Id.*

CONCLUSION

The Petitioner has not established any compelling reasons for this Court to grant the Petition. Therefore, the Respondent respectfully requests that the Petition be denied.

Respectfully submitted,

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